

DEVOLUTION AND NURSING
WORKFORCE POLICY AND PLANNING IN
THE FOUR COUNTRIES OF THE UNITED
KINGDOM 1997-2009

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Abstract

This thesis examines how political devolution in the UK impacted upon nursing workforce policy and planning by investigating the following research questions:

- *What has been the impact of devolution on nursing workforce policy and planning across the four countries of the UK (1997-2009)?*
- *How and why have the approaches to nursing workforce policy and planning changed across the four countries of the UK (1997-2009)?*

The research methodology used was a mixed methods approach which included semi-structured interviews with 30 stakeholders from the fields of nursing, healthcare policy or workforce planning across the UK. A purposive sampling strategy was adopted and the distribution of interviewees was England (11), Scotland (7), Wales (6) and Northern Ireland (6).

A realist review approach to inquiry was taken which involved establishing what works for who, in what circumstances and why? The qualitative data from the interviews was supplemented by analysis of quantitative data on nursing workforce trends and information from the analysis of health policies from the four countries.

The key findings include: changing patterns of power and influence in the devolved administrations; continued cycles of 'boom and bust' in nursing workforce supply; variable growth in the nursing workforce across the UK; the unwillingness of England to 'let go' and the perception by interviewees that some national nursing policies were unimportant.

The conclusions were that although devolution enabled greater freedoms in terms of policy and workforce flexibility, just under half of the interviewees reported that devolution had a positive impact upon nursing. There was reluctance from senior nursing leaders to share and learn from good practice across countries and despite the rhetoric from numerous reports around the need to improve nursing workforce planning, there was little evidence of lessons being learned which would have improved the effectiveness of planning the future nursing workforce.

Key Words:

nursing workforce planning; nursing workforce policy; United Kingdom devolution; realist review.

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Chapter One – Setting the Context

1.1 Introduction and Research Questions

Devolution, the decentralisation of power from the Whitehall Government in London to the three devolved administrations in Scotland, Wales and Northern Ireland was established in law by the Labour Government in 1998 and introduced in 1999. Devolution extended to only 15% of the United Kingdom (UK) (Paun and Hazell 2008).

As healthcare is a devolved matter this has resulted in each country of the UK having increased but varying degrees of legislative powers over policy and planning matters related to the National Health Service (NHS). Since devolution each country has developed different policies and approaches to address the health needs of their local populations.

Although programmes of research have been undertaken to investigate the impact of UK devolution on health services (including Hazell and Jervis 1998; Jervis and Plowden 2003; Greer 2003; Greer and Trench 2008, Jervis 2008) there is an absence of research into the impact of devolution specifically upon nursing. The literature published on this is confined to examples of commentary on what devolution means for nursing (including Catton 1999; Bradley 2000; O'Neill 2000; Maslin-Prothero, Masterson and Jones 2008; Fyffe 2008, Moore 2009) but there are no known published research studies specifically on the impact of UK devolution on nursing workforce policy or nursing workforce planning.

The key focus of this thesis is to address this gap in the research and compare approaches to nursing workforce policy and planning across the four UK countries over the period when devolution was being implemented and the subsequent decade (1997-2009), with the intention of establishing a greater insight into the impact of devolution. The main evidence base for this thesis is the data from qualitative interviews conducted in 2008 with 30 key stakeholders from the fields of nursing policy and workforce planning.

This study investigates the following two research questions:

- *What has been the impact of devolution on nursing workforce policy and planning across the four UK countries 1997-2009?*
- *How and why have the approaches to nursing workforce policy and planning changed across the four UK countries 1997-2009?*

At the time of the fieldwork for this study in 2008 there were 622,851¹ nurses, midwives and related support staff working in the NHS in the UK, 70% of which were Registered Nurses or Midwives. As nurses are the main deliverers of patient care, robust systems of workforce planning are essential to ensure an adequate supply of the nursing workforce, with the right skills and competencies, to meet future healthcare needs and provide safe and effective patient care. If there are insufficient nurses in the workforce then short term temporary staffing solutions, for example bank and agency staff, may be relied upon and these can be more expensive options with the potential to have an adverse impact upon the quality of patient care.

The study focuses primarily on all four fields² of nursing (adult, children, mental health and learning disability) but excludes midwifery. The rationale for the exclusion of midwifery is that it is a separate professional group from nursing, governed by a range of distinct health policies and has a specific set of workforce issues. It should be noted that some of the data included in the study is for the nursing and midwifery workforce and this has been used only where it was not been possible to obtain a separate breakdown for the nursing workforce.

¹ This figure relates to headcount and was derived from a collation of official government datasets from each of the four UK countries.

² Previously referred to as branches of nursing.

1.2 Development of a Conceptual Framework

1.2.1 Rationale for the Conceptual Framework

As this research study spans the four countries of the UK (England, Scotland, Wales and Northern Ireland) over the twelve year period from 1997-2009, there was a need to develop an approach to the research that would enable a significant volume of policy information and literature to be reviewed, analysed, synthesised and contextualised.

At the outset of undertaking a research study the researcher will have some ideas about the phenomenon under study but at this stage further thinking will be required to develop the research questions and formulate the underpinning theory (Miles and Huberman 1994). In order to facilitate this process a conceptual framework was developed which provided a systematic approach and subject matter boundaries for the policy analysis and literature review. Teddlie and Tashakkori described the process of developing a conceptual framework as being 'highly inductive' (2009, p.89). In this thesis it was used to frame the overall research process including formulating the research questions, the development of the schedules for the key informant interviews as well as providing a structure to ensure a consistent sequencing of information reported through the literature review and the presentation of findings.

The conceptual framework developed for the study was informed by the work of Miles and Huberman (1994, p.18) who described the key purpose of the framework as being a means of explaining 'the main things to be studied – the key factors, constructs or variables – and the presumed relationships among them'. A conceptual framework has also been described as being a 'model of what is out there that you plan to study, and of what is going on with these things and why - a tentative theory of the phenomena that you are investigating' (Maxwell 2005, p.33). The process of developing the conceptual framework for the study provided the researcher with the opportunity to plot out the key themes visually and to explore the potential

linkages between the themes in a more meaningful way than could have been achieved through the use of narrative alone.

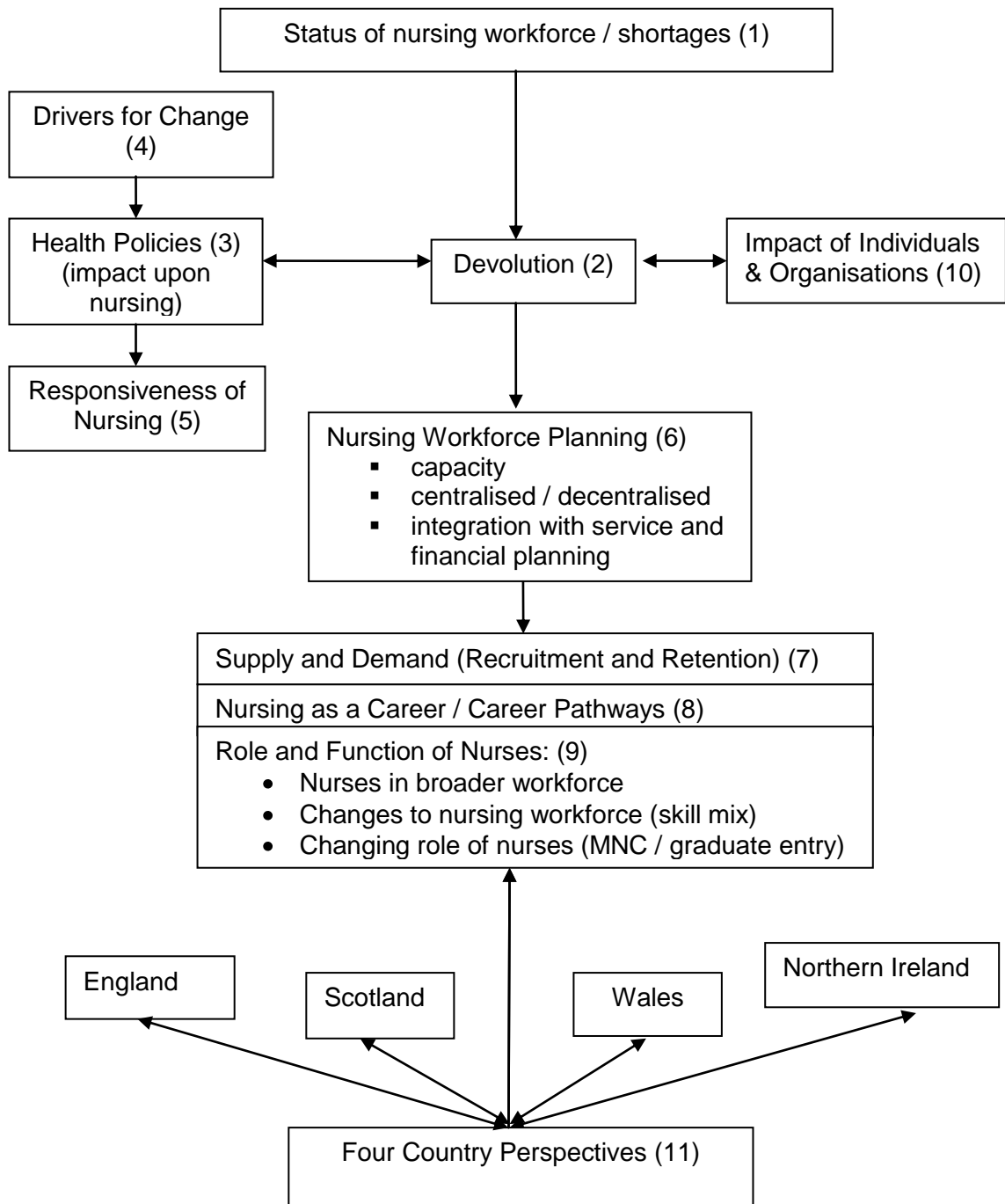
1.2.2 Developing the Conceptual Framework

The development of the conceptual framework for the study was an iterative process which evolved as the researcher tested out different ways of ordering and presenting the information until the final version of the framework was achieved. The final version of the conceptual framework, which was used in the study is outlined below and is shown at Figure 1.1. Earlier versions of the conceptual framework are included in Appendices I, II and III for information and to illustrate the process of iteration.

The conceptual framework was informed by the researcher's professional background and previous work experience, and by the policy analysis, initial review of the literature and the views of experts in the field of nursing workforce policy and planning.

The key components of the conceptual framework and the inter-relationships between the individual elements will now be considered in more detail. The numbers in brackets link to points on the framework outlined below.

Figure 1.1 Final Conceptual Framework (Version Four)



Adapted from Miles & Huberman (1994)

The starting point for this study was the researcher's interest in the status of the nursing workforce and the repeated cycles of reported workforce shortages (1). The researcher wanted to develop greater insight into the factors which contributed to the fluctuations in the nursing workforce and began to identify potential influencing factors. Central to this study was the impact of devolution (2) on the nursing workforce and how nursing workforce policy and planning has evolved with devolution.

Following devolution, health policies were implemented in each of the three devolved countries in line with the new strategies of the respective governments and health departments (3) and many of these policies had implications for the nursing workforce. New health policies were also implemented in England reflecting the priorities of the Whitehall government. Within each of the devolved administrations there were drivers for change (4) which influenced policy development, for example changing health needs of the population or the identification of new healthcare treatments. The implementation of healthcare policies frequently have implications for the nursing workforce, which may include the need for more nurses, changes in the registered to non-registered ratio or for nurses to acquire new skills to work in different ways or in alternative settings (5). This in turn influences nursing workforce planning (6), nursing recruitment and retention (7), nursing career paths (8) and nursing roles (9).

In undertaking this research, the researcher also wanted to understand if the patterns of power and influence had changed as a consequence of devolution and the associated implications for nursing workforce policy and planning (10). The UK-wide implications of each of the factors outlined in the conceptual framework were considered initially, followed by a review of the areas of similarity or difference between the four countries (11).

1.2.3 Implementing the Conceptual Framework

The conceptual framework was used to support a consistent approach to analysis throughout the study and resulted in the same headings being used both for the literature review and for the analysis of data and reporting of findings sections of this thesis:

- devolution
- key health policies ³
- nursing workforce planning
- nursing recruitment and retention.

1.3 Background to Researcher's Interest in Nursing Workforce Planning

In this section the researcher explains the background to her interest in nursing workforce planning and provides an overview of her prior experience in this area. It also outlines the rationale for the specific focus of this research on the impact of devolution on nursing workforce policy and planning.

Throughout a varied nursing career, the researcher developed a desire to ensure that nursing workforce planning is given sufficient consideration and is undertaken in an efficient and effective manner. This interest in NHS policy and nursing workforce planning began in the early 1990s when the researcher worked as a Ward Sister in a busy ward in an acute hospital and was keen to use a robust methodology to ensure appropriate staffing levels enabling the delivery of high quality patient care.

During the mid 1990s the researcher was employed as a Project Nurse for a Hospital Redevelopment Project in Edinburgh and one of her specific responsibilities was to determine the future nurse staffing requirements for the entire organisation, capitalising on opportunities for new ways of working across professional boundaries and in line with efficient hospital design

³ As there is a separate chapter on key health policies (chapter two), which precedes the literature review (chapter three) there is not a section on key health policies within the literature review.

principles. Consequently the researcher developed a greater knowledge of this subject area and an understanding of the tools and techniques available to support planning for the nursing workforce.

Several years later the researcher was seconded to the Scottish Executive Health Department as the Programme Manager for Nursing Workload and Workforce Planning and led a national project across NHSScotland, which resulted in the publication of the *Nursing and Midwifery Workload and Workforce Planning Project* report (Scottish Executive Health Department 2004a). It was following completion of this report that the researcher decided to embark upon a PhD study on this topic. Whilst researching this area it became clear that although significant attention had been placed on the impact of devolution in the UK there was a lack of research looking specifically at the impact of devolution on nursing policy or nursing workforce planning. The researcher became keen to undertake a study into this subject matter including gaining a greater insight into how health policy has diverged in the four countries following devolution and how this has affected nursing workforce policy and planning, including nursing recruitment and retention.

When the researcher embarked upon this research in 2005, as a part-time PhD student, she was seconded from NHS Lothian to the Scottish Executive Health Department. This provided her with valuable experience and insight of working within a devolved administration. The researcher subsequently relocated to England and since 2006 has been employed full time within the NHS in England, latterly working within a Local Education and Training Board of Health Education England.

Additionally, in 2009 the researcher was awarded a Florence Nightingale Foundation Travel Scholarship to visit Canada to examine the nursing workforce planning systems in place in Ontario and to identify what learning could be applied to the UK healthcare context.

Overall this professional background and experience has resulted in the researcher having a sound understanding of the complexities of nursing workforce policy and planning with the aspiration to undertake further research in this area.

1.4 Summary of Key Points

This chapter provided an introduction to the research questions; an overview of the conceptual framework developed to inform the structure of the thesis and the background to the researcher's interest in nursing workforce policy and planning. In the next chapter the key health policies from each of the four countries over the period 1997 – 2009 will be presented and the implications for nursing workforce policy and planning considered.

Chapter Two – Health Policy Analysis

2.1 Introduction to the Policy Analysis

This chapter provides an overview of the policy terrain across the UK over the period under review and it focuses on the policies of relevance to the nursing workforce issues examined in this thesis. At the outset of this study the researcher undertook a preliminary analysis of the health policies from each of the four UK countries. The aim of the policy analysis was to identify the main policy themes and areas of consistency and divergence between the four countries, which focused directly or indirectly on nursing workforce issues. The particular focus of this work was to gain a broad understanding of the policy context in each country at the outset of the study period in 1997 through to the key informant interviews in 2008. During the course of this research, some policies were also considered from 2009, the year after the interviews, and the principal reason for this was to provide further context to the data analysis and findings sections of the thesis. Additionally several of the policies published during 2009 were in development at the time of the interviews and some interviewees may have been involved in this policy development work.

This policy analysis assisted the researcher to develop and refine the conceptual framework for the study, as discussed in chapter one. The policy analysis also provided background information for inclusion in the literature review for example details of health policy divergence between the four UK countries is included in the devolution section, whilst policies related to nursing workforce planning or nursing recruitment and retention are summarised in these sections of the literature review. Furthermore the policy analysis enabled the researcher to identify themes for further investigation during the semi-structured interviews.

The researcher identified the health policies from each country principally through searches of the websites of the government health departments in

England, Scotland, Wales and Northern Ireland and from the reference listings in some policy documents and reports. At the outset of this study the researcher reviewed the health policies published in each of the four countries over the study period to distill the key themes and record the main implications for the healthcare workforce, particularly nursing. Throughout the research study an awareness of more current policy publications was maintained by reviewing health or nursing journals.

A table was developed for each of the four countries and all the health policies reviewed were listed in chronological order in the relevant table. Owing to the sheer volume of health policy documents developed across the four countries of the UK over the twelve year period under review, it was beyond the scope of this thesis to include an in-depth analysis of all the policy documents published. A summary listing of the policies analysed has been prepared for each of the four countries. The policy and key event information for Scotland is included as an exemplar in table 2.1 below, whilst the policy and key event information for England, Wales, Northern Ireland and the UK is included in Appendices IV, V, VI and VII.

Table 2.1 Scotland - Policy / Event Log

Policy / Key Event (Scotland)	Date
Student Nurse Intake Planning (SNIP) introduced.	1996
<i>Designed to Care: Renewing the National Health Service in Scotland</i> (Scottish Office).	1997
<i>Towards a New Way of Working – the Plan for Managing People in the NHS in Scotland. Performance Through People</i> (Scottish Office).	1998
<i>Modernising Community Care</i> (Scottish Office).	1998
<i>Acute Service Review</i> (Scottish Office).	1998
The Scotland Act .	1998
<i>Towards a Healthier Scotland. A White Paper on Health</i> (Scottish Office).	1999
<i>Making it Work Together a Programme for Government</i> (Scottish Executive).	1999
<i>Fair Shares for All: The Report of the National Review of Resource Allocation for the NHS in Scotland</i> (Arbuthnott Committee).	1999

Policy / Key Event (Scotland)	Date
<i>Learning Together – A Strategy for Education, Training and Lifelong Learning for all staff in the National Health Service in Scotland</i> (Scottish Executive Health Department).	1999
Devolution introduced in Scotland.	1999
<i>Our National Health: A Plan for Action, a Plan for Change</i> (Scottish Executive Health Department).	2000
<i>Temporary Measures Managing Bank and Agency Staff</i> (Accounts Commission).	2000
Report of the Joint Future Group.	2000
<i>Caring for Scotland. The Strategy for Nursing and Midwifery in Scotland</i> (Scottish Executive Health Department).	2001
<i>Nursing for Health – a Review of the Contribution of Nurses, Midwives and Health Visitors to Improving the Public's Health in Scotland</i> (Scottish Executive Health Department).	2001
Pilot of Family Health Nurse.	2001
Launch of Facing the Future Group.	2001
<i>Facing the Future. Report of the 19th November 2001 Convention on Recruitment and Retention in Nursing and Midwifery</i> (Scottish Executive Health Department).	2001
<i>Planning Together</i> (Scottish Integrated Workforce Planning Group)	2002
<i>Response to Planning Together. Final Report of the Scottish Integrated Workforce Planning Group</i> (Scottish Executive Health Department).	2002
<i>Planning ward nursing – Legacy or Design?</i> (Audit Scotland).	2002
<i>Working for Health: The Workforce Development Action Plan for NHSScotland</i> (Scottish Executive Health Department).	2002
<i>Choices and Challenges: a Strategy for Research and Development in Nursing and Midwifery in Scotland</i> (Scottish Executive Health Department).	2002
National Workforce Committee established.	2002
National Workforce Planning Unit established.	2002
NHS Education for Scotland (NES) established as a Special Health Board.	2002
<i>Promoting Health, Supporting Inclusion: the National Review of the Contribution of all Nurses and Midwives to the Care and Support of People with Learning Disabilities</i> (Scottish Executive Health Department).	2003
<i>Partnership for Care: Scotland's Health White Paper</i> (Scottish Executive Health Department).	2003
<i>A Scottish Framework for Nursing in Schools</i> (Scottish Executive Health Department).	2003
<i>A Partnership for a Better Scotland: the Policies and Programme for the Scottish Executive for the Next Four Years 2003-2007</i> (Scottish Parliament).	2003

Policy / Key Event (Scotland)	Date
<i>Improving Health in Scotland – the Challenge</i> (Scottish Executive Health Department).	2003
NHS Reform Bill.	2003
<i>Nursing and Midwifery Workload and Workforce Planning Project</i> (Scottish Executive Health Department).	2004
<i>Framework for Nursing in General Practice</i> (Scottish Executive Health Department).	2004
<i>Nursing People with Cancer in Scotland: a Framework</i> (Scottish Executive Health Department).	2004
<i>Fair to All, Personal to Each</i> (Scottish Executive Health Department).	2004
<i>Scottish Health Workforce Plan 2004 Baseline</i> (Scottish Executive Health Department).	2004
NHS Reform (Scotland) Act.	2004
Amendment introduced to NHS Reform Act which placed a statutory duty on all NHS Boards to have in place arrangements for workforce planning	2004
NHS Trusts disbanded and replaced by 14 Health Boards.	2004
Appointment of new Chief Nursing Officer – Paul Martin.	2004
Workforce Numbers Group established .	2004
<i>Nationally Co-ordinated Nurse Bank Arrangements Report and Action Plan</i> (Scottish Executive Health Department).	2005
<i>Framework for Developing Nursing Roles</i> (Scottish Executive Health Department).	2005
<i>Building a Health Service Fit for the Future A National Framework for Service Change in the NHS in Scotland</i> (Scottish Executive Health Department).	2005
<i>Delivering for Health</i> (Scottish Executive Health Department).	2005
<i>Delivery through Leadership</i> (Scottish Executive Health Department).	2005
<i>National Workforce Planning Framework</i> (Scottish Executive Health Department).	2005
<i>The Impact of Nursing on Patient Clinical Outcomes – Developing Quality Indicators to Improve Care</i> (NHS Quality Improvement Scotland).	2005
<i>Reshaping the NHS? Workforce planning in the National Health Service in Scotland</i> (Scottish Parliament Health Committee)	2005
<i>Building a Health Service Fit for the Future. A National Framework for Service Change in the NHS in Scotland</i> (Scottish Executive Health Department).	2005
<i>Delivering for Health</i> (Scottish Executive Health Department).	2005
Review of Student Nurse Intake Planning.	2005
National Workforce Planning Framework introduced.	2005

Policy / Key Event (Scotland)	Date
<i>National Workforce Plan 2006</i> (Scottish Executive Health Department). Report from the first year of the new workforce planning cycle.	2006
<i>Rights, Relationships and Recovery – the Review of Mental Health Nursing in Scotland</i> (Scottish Executive Health Department).	2006
<i>From Knowing to Doing: Transforming Knowledge into Practice in NHSScotland</i> (NHS Education for Scotland).	2006
<i>Visible, Accessible and Integrated Care – Report of the Review of Nursing in the Community in Scotland</i> (Scottish Executive Health Department).	2006
<i>Delivering Care, Enabling health. Harnessing the Nursing, Midwifery and Allied Health Professions' Contribution to Implementing Delivering for Health in Scotland</i> (Scottish Executive Health Department).	2006
<i>The WHO Europe Family Health Nursing Pilot in Scotland: Final Report</i> (Scottish Executive Health Department).	2006
<i>Code of Practice for the International Recruitment of Healthcare Professionals in Scotland</i> (Scottish Executive Health Department).	2006
<i>Better Health, Better Care Action Plan</i> (Scottish Government).	2007
<i>Better Health Better Care Planning Tomorrow's Workforce Today</i> (Scottish Government).	2007
<i>Implementation of Nursing and Midwifery Workload and Workforce Planning Tools and Methodologies CEL 6</i> (Scottish Executive).	2007
<i>Nursing and Midwifery Workload and Workforce Planning Project. A Good Practice Guide in the Use of Supplementary Staffing</i> (Scottish Government).	2007
<i>Recruitment and Retention. Report of Facing the Future Sub Group and Working Groups</i> (Scottish Government).	2007
<i>Planning Ward Nursing – Legacy or Design. A Follow Up Report</i> (Audit Scotland).	2007
<i>Leading Better Care. Report of the Senior Charge Nurse Review and Clinical Quality Indicators Project</i> (Scottish Government).	2008
<i>Advanced Nursing Practice Toolkit</i> (Scottish Government).	2008
<i>Healthcare Support Workers in Scotland: Evaluation of a National Pilot of Standards and Listing in Three NHS Boards</i> (Scottish Government).	2009
<i>Code of Practice for Employers of Healthcare Support Workers in Scotland</i> (Scottish Government).	2009
<i>A Force for Improvement: the Workforce Response to Better Health Better Care</i> (Scottish Government).	2009

2.2 Healthcare Policies from 1997 to 1999

Shortly after the election of the Labour Government in 1997, policies were developed in England, Scotland and Wales which outlined the strategic vision for healthcare within the respective countries (Department of Health 1997; Scottish Office 1997; Secretary of State for Wales 1998). Although these policies detailed plans for specific structural reform of the health services within each country there were several common themes across the policies including:

- changes to the internal market, introduced by the Conservative Government in 1991, which separated the functions of the purchase and provision of healthcare (Department of Health, 1989). The internal market was terminated in Scotland and modified in England and Wales. GP fund-holding was also abolished across the UK (Health Act 1999)
- the need to improve access to care and an increased focus on the quality of care
- a stronger emphasis on partnership working both with patients and between agencies
- a shift towards the provision of more services in primary care, including greater opportunities for healthcare professionals to shape local services including the development of nurse led clinics and one-stop diagnostic clinics.

There was less policy activity in Northern Ireland where, during the period 1997-1999, the main focus of attention was a consultation on the future arrangements for health and social care. This consultation outlined proposals for the establishment of a new body the Department of Health, Social Services and Public Safety aimed at maximising the benefits of the country's unique integrated health and social care system along with other structural reforms to support this new body (Department of Health and Social Services 1998a).

There was also a policy focus in the UK countries aimed at the rationalisation of acute hospital services, with a view to providing safer and more cost effective services for acute patient care (Scottish Office 1998a; Department of Health and Social Services 1998b; National Assembly for Wales 2000a⁴).

Overall the commonality in healthcare policy themes in England, Scotland and Wales between 1997 and 1999 was principally due to one political party being in Government across these countries. At this time in Northern Ireland there was a greater focus on health and social care restructuring and less health policy activity.

2.3 Healthcare Policies Post-Devolution

2.3.1 Overview

Following the introduction of devolution in 1999 there was evidence of greater health policy divergence between the four UK countries, although it took some time for these differences to emerge. Two years after the introduction of devolution in 2001, it was reported that the Green and White papers from the different countries detailed 'challenging agendas which would not be implemented overnight' (Constitution Unit 2001, p.8), however differences were already emerging in the way health services were being delivered particularly primary care services. At the outset of devolution there was also a commitment from all four countries to deliver policies rooted in 'investment and reform' (Woods 2004, p.337) and related to this targets were set for nursing workforce growth in England, Scotland and Wales. The different policy priorities for each of the four countries are outlined in the sections below.

2.3.2 England

The NHS Plan. A plan for investment. A plan for reform (Department of Health 2000a) outlined plans for the NHS in England over the next decade. The key focus of this policy was on 'modernisation' of the health service.

⁴ This publication was the year following devolution in Wales.

Commitments were made to cut waiting times, reduce health inequalities, address inequities in access to care, improve quality of care and cleanliness of hospitals. These reforms would be delivered through re-design of services, supported by the NHS Modernisation Agency, and an increased focus on performance management. Core national standards and performance targets would be monitored and action taken where healthcare organisations were seen to be failing. The *NHS Plan* also included proposals for a concordat between the NHS and Private Sector enabling the NHS to make use of extra capacity in this sector to benefit the care and treatment of NHS patients.

Commitments were made to improve pay and working conditions for NHS staff along with increased numbers of staff including targets for 20,000 additional nurses and 1,000 Nurse Consultants. The Modern Matron role, unique to the English healthcare context, was introduced to oversee the quality of care in clinical areas. Opportunities were cited for nurses to take on new roles and increased responsibilities.

The publication of *The NHS Improvement Plan Putting People at the Heart of Public Services* (Department of Health 2004a) reinforced the principles of reform and improved performance associated with implementing the second phase of *the NHS Plan*. The focus of this policy was on the next stage of the NHS in England's journey to: 'ensure that a drive for responsive, convenient and personalised services takes root across the whole of the NHS and for all patients' (p.8). It emphasised the need for staff to work flexibly and in new ways to deliver more personalised patient care in a modernised health service.

Subsequently, the NHS Next Stage Review programme of work led by Professor the Lord Darzi, required each of the ten Strategic Health Authorities in England to develop plans to transform services across eight defined care pathways; staying healthy; maternity and newborn; children;

acute care; planned care; mental health; long term conditions and end of life. The principal aim of *A High Quality Care for All: NHS Next Stage Review* (Department of Health 2008a) was to stimulate locally led changes across these care pathways which were both patient focused and clinician driven. There was a strong emphasis on improving the quality of care, increasing patient choice and creating opportunities for greater personalisation in healthcare.

The key role of nurses in leading and delivering these improvements was highlighted in *A High Quality Care for All*, whilst the accompanying policy document *A High Quality Workforce* (Department of Health 2008b) detailed the expectations of clinicians in delivering the aims of the *NHS Next Stage Review*. This included work to 'reaffirm the role of the nurse' and update definitions of current day nursing; develop mechanisms to measure the quality of nursing care; increase investment in preceptorship periods for newly qualified staff; greater flexibility in career paths including strengthening clinical academic careers; new national standards for advanced nursing roles and the proposal to explore options for graduate entry to pre-registration nursing (Department of Health 2008b, p.18).

2.3.3 Scotland

In Scotland *Our National Health: A Plan for Action, a Plan for Change* (Scottish Executive Health Department 2000) outlined plans to re-build the NHS and identified the national priorities for health. There was a clear focus on the opportunities for health created through devolution. Increased investment would be directed at improving health and creating a health service fit for the 21st century. Proposals included a national health improvement fund, increased hospital redevelopment programmes, new GP practices and community health services. Managed Clinical Networks would be established linking local and regional services, strengthening clinical leadership and improving the quality of care. The key clinical priorities were reaffirmed as being: coronary heart disease, cancer and mental health.

Commitments were made to modernise pay for NHS staff, in line with the other UK health departments and there was increased investment planned to support learning and development. Partnership working with staff was seen as essential as was the need to develop consistent personnel policies for use across the NHS in Scotland.

The Partnership Agreement committed to bring 12,000 nurses and midwives into the NHS by 2007 as part of an initiative to deliver improvements in the NHS in Scotland (Scottish Executive Health Department 2003a).

In 2005, *Building a Health Service Fit for the Future* commonly known as the 'Kerr Report' was published (Scottish Executive Health Department 2005a). The recommendations included the rationalisation of specialist and complex care into fewer centres to reduce clinical risk; the importance of supported self care for long term conditions; maintaining local services particularly to meet the needs of remote and rural areas; harnessing the use of telemedicine and information technology to improve efficiencies and further action to reduce waiting times and health inequalities. It acknowledged that in order to deliver these changes a re-profiling of the existing workforce was required including investment in education and training to develop new ways of working for example the implementation of Hospital at Night teams. There were opportunities for nurses to have a lead role in these new teams.

Delivering for Health (Scottish Executive Health Department 2005b) the Government's response to *Building a Health Service Fit for the Future* (Scottish Executive Health Department 2005a) endorsed the report's recommendations and identified actions aimed at shifting the balance of care from acute hospitals to an increased delivery of health and wellbeing services in the local community. It also included plans to strengthen performance management of key priorities and targets.

Following the change of Government in Scotland in 2007, the strategic vision of the new Scottish National Party was outlined in the *Better Health, Better Care: Action Plan* (Scottish Government 2007a). There were three main themes in this policy:

- developing a 'mutual' NHS
- supporting health improvement and tackling health inequalities, with a particular focus on disadvantaged communities
- better, local access to healthcare including improved patient safety, quality, efficiency and effectiveness.

Central to this policy was the concept of a mutual NHS where the public and staff are partners in the NHS. This included a prominence on the shift in the ownership and responsibility for health to individual citizens. Performance management targets were revised to address health improvement; efficiency and governance; access and treatment. The importance of Managed Clinical Networks was reinforced and plans were included to expand and strengthen these. There was a clear statement in the policy foreword detailing that NHSScotland was distancing itself further from the '*market orientated models*' (Scottish Government 2007a, p.v), which was Scotland signaling its rejection of the model of healthcare in place in England.

Although the *Better Health, Better Care: Action Plan* made specific reference to workforce planning, new roles and leadership development, a related document '*Better Health, Better Care: Planning Tomorrow's Workforce Today*' (Scottish Government 2007b) was published outlining proposals to deliver further improvements in workforce planning, including developing workforce planning capacity at NHS Board level. There was also a focus on creating new roles based on patient needs and the importance of education and training for both the current and future healthcare workforce.

2.3.4 Wales

In 2001 *Improving Health in Wales: a Plan for the NHS and its Partners* (National Assembly for Wales 2001a) set the strategic direction for the NHS in Wales over the next decade. The main focus was on improving health and addressing inequalities in health. The vision was for an integrated healthcare system across primary, secondary and tertiary services, with stronger partnership working across organisational boundaries and greater patient involvement. This plan also committed to modernising pay and terms and conditions for staff and a number of initiatives were included to ensure the workforce was prepared for future roles: for example leadership development, partnership working, reviews of job design and increased opportunities for flexible working.

Building upon and updating the work of *Improving Health in Wales*, in 2005 a further ten year strategy was published *Designed for Life – Creating World Class Health and Social Care for Wales in the 21st Century* (Welsh Assembly Government 2005a) the focus of this policy was on promoting a national health service for the people of Wales, as opposed to a national illness service. This vision encompassed increased personal responsibility for health and well-being amongst the public. Targets were included for prevention, better access to services and improvements in quality for the following priorities: mental health; chronic disease management; children and young people's services; older people's services and cancer services. A range of enablers were identified encompassing performance management; service reconfiguration; professional leadership; clinical networks; research and evaluation; education, training and workforce re-design. A commitment was made for 6,000 additional nurses and the development of a workforce strategy to support the implementation of *Designed for Life*.

In 2006 *Designed to Work* (Welsh Assembly Government) was published and this workforce strategy was aimed at supporting the development of new roles and different ways of working. The key principles included more

responsive workforce planning and education commissioning; working in partnership with staff to deliver change and workforce re-design based on patient pathways, across both professional and organisational boundaries. This strategy also included the introduction of two new organisations: the Workforce Development and Contracting Unit and the National Leadership and Innovation Agency for Healthcare.

2.3.5 Northern Ireland

It was reported that after the prolonged period of direct rule from Westminster, the resultant position in Northern Ireland was that health policies were out of date and did not meet the needs of the population, additionally the delivery of structural change was slow (Greer 2001). The political situation in Northern Ireland resulted in a culture of 'minimal policy activity' where the main focus was on keeping health and social care services running during the civil war (Greer 2004a, p.159).

Between 1999 and 2002 the policy activity in Northern Ireland was centred on developing primary care services and reviewing acute care provision (Department of Health, Social Services and Public Safety 2000, 2001, 2002a). Following the suspension of the Northern Ireland Assembly in October 2002 and the consequent reversion back to direct rule by Westminster, the policy activity was mainly directed at modernising health and social services in Northern Ireland (Department of Health, Social Services and Public Safety 2004; 2005a).

The sections above provided an outline of the key policy documents in each of the four countries, however there was one particular area of common policy across the four countries worthy of note which was the shift of care from acute hospitals into community settings.

2.3.6 Shift in Care to the Community

Over the period since devolution, a range of health policies have been developed detailing the need to shift care from acute hospital settings to the community or primary care (including Department of Health 2001a, 2006a, 2008a; Scottish Executive Health Department 2003b, 2005a, 2005b, 2006a; National Assembly for Wales 2001a, 2001b; Welsh Assembly Government 2003a, 2005a 2007; Department of Health, Social Services and Public Safety 2001, 2004; 2005a, 2005b). Integral to these policies was a greater emphasis on working in partnership with patients and service users.

2.4 Summary of Health Policies and the Implications for Nursing

The policy analysis provided background information on the health policy landscape in each of the four countries over the period 1997 to 2009. It outlined an overview of the strategic visions for healthcare in each of the four countries and set the context for the interviews in 2008.

Different areas of policy were given notably more attention in specific countries. For example in England there was a greater emphasis on quality improvement and performance management. Scotland was more focused on collaboration and engagement with professionals and patients, whilst priorities in Wales were aimed at improving public health and reducing inequalities.

Differentiation in policies in Northern Ireland was less noticeable but this was mainly due to the fact that for approximately half of the review period, Northern Ireland was under direct rule from Westminster. When devolution was restored in 2007 there were wider political and policy issues which needed to be addressed and therefore there was less health policy activity in Northern Ireland than in the other three countries.

The policy divergence across the four countries had potential implications for nursing and the targets for nursing workforce growth, set in three of the four countries, would require extensive recruitment activity.

The policy drive for shift in care from acute to community settings across all four countries would require nurses employed in acute settings to be trained to work autonomously in community settings. Additionally the increased focus on primary care and reducing health inequalities would require nurses to work in new roles for example as Case Managers or Community Matrons promoting the principles of supported self-care and personalisation, working with people with long term conditions to improve health and avoid admissions to acute hospitals. The opportunities created for nurses to expand their roles, through the introduction of non-medical prescribing, were also critical in supporting the changing focus of care to community and primary care settings.

In addition to the nursing workforce implications of shift in care from acute to community settings, the centralisation of specialist services onto fewer acute hospital sites would necessitate highly skilled nursing staff being employed in the specialist centres but equally nurses working in the district general hospital settings would require skills in the early recognition of deteriorating patients. Overall the combination of these healthcare policies and the new service reconfigurations has significant implications for the knowledge and skills required of the future nursing workforce.

2.5 Human Resource and Nursing Strategies

Over the period under review in this thesis (1997-2009) each of the four countries published a Human Resource Strategy and at least one Nursing Strategy. As this thesis is concerned with the changing approaches to nursing workforce policy and planning these policies were reviewed by the researcher to identify the key implications for the NHS workforce and nursing in particular.

2.5.1 Human Resource Strategies

The development of a Human Resource strategy in each country highlighted an increased recognition of the importance of the workforce in delivering high quality care. The strategies were significant policies in term of determining the future direction for the NHS workforce, of which nursing is the largest staff group.

In England, *Working Together: Securing a Quality Workforce for the NHS* (Department of Health 1998), outlined proposals for recruiting, retaining and developing the NHS workforce to support modernisation of the health service in England. It included requirements for organisations to deliver improved retention rates; reduced sickness / absence rates; training and development plans and for annual workforce plans to be implemented by 2000.

In Scotland, *Towards a New Way of Working – the Plan for Managing People in the NHS in Scotland* (Scottish Office 1998b) included a commitment to deliver partnership working and the creation of the Scottish Partnership Forum. Other actions in this strategy included the promotion of fair employment practice; opportunities for flexible working through family friendly policies; the importance of life long learning realised through education and training plans and the establishment of the Scottish Integrated Workforce Planning Group, as the single advisory group for strategic workforce planning.

In Wales, *Delivering for Patients* (National Assembly for Wales 2000b) focused on the development of a high quality, motivated and competent healthcare workforce; appropriate staffing levels and a national recruitment and retention initiative for all healthcare professions in Wales.

In Northern Ireland, *The Employer of Choice. A Strategy for Managing and Developing People in the Health and Personal Social Services* (Department

of Health, Social Service and Public Safety 2002b), included proposals for comprehensive workforce planning across all healthcare professions; strategies for improved recruitment and retention; reduced reliance on temporary staff; lower sickness / absence rates and a range of education and training initiatives.

Overall, the content of each of the four countries' Human Resource Strategies was broadly consistent, although the strong focus on partnership working was unique to Scotland. The key priorities common to the Human Resource strategies related to improved recruitment and retention, commitments to develop the existing workforce, increased opportunities for flexible working and reduction in sickness / absence rates.

2.5.2 Nursing Strategies

Over the period 1998 to 2001, the Chief Nursing Officer in each of the four countries published a Nursing Strategy, essentially detailing the vision and ambition for the nursing profession in the respective countries.

The first of these four Nursing Strategies was published by Northern Ireland. *Valuing Diversity – a way forward* (Department of Health and Social Services 1998c) acknowledged the need to reshape the profession to meet the healthcare needs of the next millennium, particularly through an increased focus on health promotion and illness prevention. It highlighted that 'the problems with role negotiation, role confusion and role blurring must be addressed' (p.17), recommending that new nursing roles must be in response to patient needs and underpinned by relevant education programmes. Test sites for nurse prescribing were announced. Opportunities for development were identified including the role of nursing in the commissioning of services to improve quality of care and the contribution of nurses to policy making. In relation to workforce planning, the need to undertake skill mix reviews in line with patient care needs and the importance of vocationally trained support staff in the nursing workforce were raised.

The Nursing Strategy in England *Making a Difference. Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare* (Department of Health 1999a), acknowledged that more nurses and greater opportunities for flexible working were required to deliver the future healthcare agenda. There was an emphasis on an increased flexibility in approaches to training through 'step on / step off' programmes, nurse cadet schemes and more 'back to nursing' courses. Additionally it recognised that the clinical grading system in existence was in need of review as it was no longer deemed appropriate for a modern health service. It outlined plans to extend nursing roles and career paths through a range of initiatives including non-medical prescribing and the creation of Nurse Consultant posts, which supported the development of new nursing career options rooted firmly in clinical practice.

Releasing the Potential. A Strategic Framework for Nursing, Midwifery and Health Visiting in Wales into the 21st Century (National Assembly for Wales 1999) highlighted the potential impact of devolution on the nursing profession through the statement:

'Nursing, midwifery and health visiting in Wales will gradually develop distinctive identify, under the guidance of the Assembly and the professions, whilst still remaining firmly within the 'family' of nursing, midwifery and health visiting throughout the UK and the rest of the world' (p.3).

This strategy was the driver for the introduction of all graduate entry to the nursing profession in Wales whilst the implementation details were included in *Releasing the Potential Briefing Paper One Creating the Potential. A Plan for Education* (National Assembly for Wales 2000c). Wales was the first UK country to introduce all graduate entry to pre-registration nurse education. Subsequently a further six briefing papers emerged from the nursing strategy and additional outcomes included the drive for increased research capacity and the creation of Nurse Consultant posts.

Caring for Scotland, The Strategy for Nursing and Midwifery in Scotland set out a range of actions to deliver modernisation of health services in Scotland (Scottish Executive Health Department 2001a), which included emphasising the caring nature of nursing; expanding career pathways; new guidance for Nurse Consultant posts; piloting of the Family Health Nurse role; proposals for widening the entry gate for pre-registration nurse training alongside a pledge that by 2005 'education providers would aim to produce 80 per cent graduates at point of registration' (p.46). It acknowledged the need for the development of a workload methodology to facilitate responsive nursing workforce planning, along with actions to improve recruitment and retention.

Subsequently in 2006 the Scottish Executive Health Department developed a new integrated strategy for nursing, midwifery and allied health professions (Scottish Executive Health Department 2006b). Scotland was the only country to publish a second strategy for the profession during the period under review. This strategy was developed principally to reaffirm professional nursing values and to support the implementation of *Delivering for Health* (Scottish Executive Health Department 2005b). It included activities in relation to building leadership capacity through succession planning and developing the future workforce through initiatives such as improved selection processes and recruitment practices; Open University programmes for pre-registration education in remote and rural areas and increasing the availability of clinical placements within the community setting. Commitments were made to review the role of the Ward Sister / Charge Nurse; further develop opportunities for Clinical Academic Careers; implement the recommendations of the *Nursing and Midwifery Workload and Workforce Planning Project* (Scottish Executive Health Department 2004a); maximise the potential from the healthcare support worker workforce and develop new roles for nurses, capitalising on opportunities such as non medical prescribing.

2.5.3 Summary on Human Resource and Nursing Strategies

The Human Resource and Nursing Strategies were developed at a time of increased funding for the NHS. The Human Resource Strategies included mechanisms to support the recruitment and retention of staff, whilst the Nursing Strategies outlined the vision for the nursing profession and were also a means of raising the profile of nursing in each country at a time of ambitious targets for nurse staffing growth.

Although the Human Resource and Nursing Strategies were developed several years before the interviews for this thesis were conducted, they were still in place at the time of the interviews. No specific evaluations have been undertaken into the effectiveness or impact of either the Human Resource or Nursing Strategies in any of the four countries.

2. 6 UK-Wide Policies with Implications for the NHS Workforce

In addition to the country specific policies discussed above, there were three particular UK policies which had implications on a UK-wide basis and which the researcher identified as being of importance to nursing workforce policy and planning. The three policies were:

- Agenda for Change
- Modernising Medical Careers
- Modernising Nursing Careers

This section highlights the nature of these policies and the associated workforce implications.

The UK-wide policy *Agenda for Change* (Department of Health 1999b) was the starting point for the development and introduction of a new pay and career system for NHS staff. It represented the largest overhaul of pay, terms and conditions and career structures for the majority of healthcare staff⁵ across the non-medical professions since the inception of the NHS. Although this policy was published in 1999, the need to negotiate and reach

⁵ The majority of NHS nurses are included under Agenda for Change but it excludes doctors.

agreement with trade unions, the scale of the associated change and the staff training requirements resulted in its implementation over the period December 2004 to December 2006. In addition to the new pay structures within *Agenda for Change*, there was also an integral Knowledge and Skills Framework aimed at delivering improvements in workforce productivity.

The implementation of *Modernising Medical Careers* (Department of Health 2004b) resulted in new medical training structures and changes in allocations of trainee doctors which created significant gaps in the medical workforce particularly at a junior level. The commonest solution to addressing this shortfall in medical cover across the UK was the substitution of the nursing workforce for the medical workforce (Simeons, Villeneuve and Hurst 2005).

Modernising Nursing Careers Setting the Direction (Department of Health; Scottish Executive; Welsh Assembly Government and Department of Health, Social Services and Public Safety 2006) was a policy collectively developed by the four country Chief Nursing Officers and aimed at creating modern, fit for purpose nursing careers across the UK. There were four key priority areas for action which were to:

- 'develop a competent and flexible nursing workforce
- update career pathways and career choices
- prepare nurses to lead in a changed health care system
- modernise the image of nursing and nursing careers' (p.17).

The report was published in each of the four countries and included an introductory message from the relevant Chief Nursing Officer tailored to the specific policy context of each respective country. In addition to this each Chief Nursing Officer was the identified lead for a specific programme of work within the strategy. England was tasked with developing consensus around post registration career pathways and developing a vision for nurse educators. Scotland's focus was on Advanced Nursing Practice; Wales was working on a programme to fast track the development of clinical leaders

along with work to empower ward sisters; whilst Northern Ireland was leading on the co-ordination and delegation of care. *Modernising Nursing Careers* was the only example of a four country nursing policy collaboration during the period under review.

The European Working Time Directive (Council Directive 1993), although not a UK policy, also impacted significantly upon the working practices of junior medical staff principally by restricting the number of hours worked each week. The policy responses to the European Working Time Directive were made at a UK level and the consequences of this reduction in junior doctor hours created significant opportunities for nurses to work in new ways in response to the gaps created and examples included Hospital at Night Practitioners, Emergency Care Practitioners, specialist and advanced nursing roles.

2.7 Summary on Health Policies

This chapter represents a synopsis of the health policies in each of the four countries and across the UK, as they impact on nursing workforce issues. It has also informed the literature review on devolution, nursing workforce planning and nursing recruitment and retention as detailed in chapter three.

During the interviews key stakeholders were asked to provide their views on the health policies which they believed had impacted most upon the nursing workforce within their respective countries over the study period. Feedback from the interviews was analysed and compared to the researcher's health policy analysis and is reported in chapter six - Analysis of Interview Data and Reporting of Findings.

Chapter Three – Literature Review

3.1 Introduction to Literature Review

The literature review was undertaken to provide the background to the political and health policy context within the four countries of the UK. It provides an insight into the key issues impacting upon the nursing workforce including nursing workforce planning. It covers the period immediately prior to devolution, the introduction of devolution and the subsequent decade (e.g. the period 1997-2009). The literature review critiques and summarises the relevant health policy documents and other reference materials related to devolution and nursing workforce policy and planning, including nursing recruitment and retention. The scope of this study covers the four countries of the UK (England, Scotland, Wales and Northern Ireland) and the literature review highlights areas of commonality and difference between the countries. It also details the limitations of the available literature and identifies the gaps in the evidence base.

At the outset of the literature review, the researcher developed a sampling strategy with clear inclusion and exclusion criteria to guide the selection of literature. This sampling strategy is detailed in table 3.1 below.

Table 3.1 Literature Review Inclusion and Exclusion Criteria

Search Criteria	Comments
Dates	The initial literature search included materials from the early to mid 1990s, which set the context before the change of Government in 1997, through to 2008. This was subsequently extended until 2009.
Language	Only English language publications were considered. The vast majority of reference material was from the UK, however some international research studies were reviewed particularly those on nursing workforce planning, with the aim of providing a wider understanding of nursing workforce planning perspectives
Type of Study	Empirical and Non-Empirical studies were included
Data Sources	A range of data sources were used in this study including: <ul style="list-style-type: none">▪ Peer Reviewed Journals▪ Professional Journals▪ Research Studies▪ Four Country Health Policy Documents▪ Policy Evaluation Reports▪ Devolution Reports▪ Audit Reports▪ Health Select Committee Reports▪ Books▪ Grey literature including unpublished PhD Theses▪ Workforce Datasets (as detailed in chapter five)
Key Words / Terms	The following key words used in the search were: <ul style="list-style-type: none">▪ nursing workforce policy▪ nursing workforce planning▪ (political) devolution in the UK▪ impact of UK devolution on health▪ nursing recruitment▪ nursing retention Combinations of these key words were also used for example devolution and nursing workforce policy. Searches were undertaken for materials from across the UK.

Search Criteria	Comments
Databases	<p>Ovid CINAHL British Nursing Index MEDLINE Health Management Information Consortium (HMIC) NHS National Library for Health – Health Management Specialist Library Royal College of Nursing Library King’s Fund Library Scottish Executive Library Constitution Unit, University College, London</p> <p>Health policies from each of the four UK countries were identified by searching each country’s health department website</p>

The structure used in the literature review follows the key themes identified in the conceptual framework as outlined previously, which were:

- devolution
- nursing workforce planning
- nursing recruitment and retention

The relevant literature will be reviewed for each of these topic areas, in order to shape the direction of the research conducted for the thesis, to identify key issues to be examined and the critical gaps in evidence for further exploration in this thesis.

3.2 Devolution

3.2.1 Introduction

This section of the literature review summarises the policy context and relevant research undertaken on devolution in the UK and identifies where gaps in knowledge exist. It covers the following areas:

- background to the development and implementation of devolution in the UK
- an overview of the healthcare structures and key policy priorities in each of the four countries
- explain the relevant reserved and devolved powers
- describe the mechanisms of power and influence in the devolved administrations, including the professional nursing leadership model in place in each country
- outline areas of health and nursing policy divergence across the four countries
- highlight gaps in the research base of relevance to this study

3.2.2 Key Sources of Data and Information

This section provides an overview of the research data sources of relevance to this study, whilst highlighting the limitations of the different approaches taken and perspectives provided. The purpose of including this information at this point in the literature review is to contextualise the limited data on devolution and health, which was available to inform this thesis.

Over the period 1999-2005 the Constitution Unit at University College, London led research on monitoring devolution⁶, the output of which was 103 reports and five volumes of the *State of the Nations* books. This was followed by a second phase of work from 2006-2008⁷. The programme of research was funded principally by the Economic and Social Research

⁶<http://www.ucl.ac.uk/constitution-unit/research/research-archive/archive-projects/devolution-monitoring99-05>

⁷<http://www.ucl.ac.uk/constitution-unit/research/research-archive/archive-projects/devolution-monitoring06-09>

Council (ESRC) Devolution and Constitutional Change Programme and the UK governments. It was undertaken in partnership with academic institutes in each of the four countries and the subject matter was devolution in the broadest sense with only limited reviews undertaken in relation to the impact of devolution on healthcare or health policy.

The Nuffield Trust, an independent UK health policy charitable trust, funded studies to monitor the impact of devolution on the UK's health systems. The reports from both the Constitution Unit and the Nuffield Trust specifically on devolution and health included: Hazell and Jervis 1998; Jervis and Plowden 2000; Jervis and Plowden 2001; Greer 2001; Greer 2003; Greer 2004b; Jervis and Plowden 2003; Greer and Rowland 2007; Greer and Trench 2008; Jervis 2008; Connolly, Bevan and Mays 2010.

In addition to the Nuffield Trust and Constitution Unit studies identified above, much of the wider literature on devolution, which included commentary on health policy as well as studies of the impact of devolution on health, focused on the extent of policy divergence between the four countries: including Freeman and Woods 2002; Woods 2002; Davies 2003; Ham 2004; Greer 2004a; Talbot, Johnson and Freestone 2004; Woods 2004; Alvarez-Rosete et al. 2005; Adams and Schmuecker 2006; Cairney 2007; Chartered Institute of Public Finance and Accountancy 2008; Maslin-Prothero, Masterson and Jones 2008; Moore 2009.

Few of these publications have commented on the implications of devolution on the healthcare workforce (including Maslin-Prothero, Masterson and Jones 2008; Jervis 2008; Greer and Trench 2008; Moore 2009; Connolly, Bevan and Mays 2010), which for nursing has resulted in the development of different roles, career paths and educational opportunities across the four countries (Maslin-Prothero, Masterson and Jones 2008 p.669).

As highlighted in the introduction to this thesis (chapter one), although there are a few examples of commentary on the potential implications of devolution on nursing (including Catton 1999; Bradley 2000; O'Neill 2000; Maslin-Prothero, Masterson and Jones 2008; Fyffe 2008, 2009; Moore 2009), there are no known published research studies which have focused specifically on the impact of UK devolution upon the nursing profession or the implications for nursing workforce policy or planning. This is one of the main reasons why the researcher has chosen to investigate the impact of devolution on nursing workforce policy and planning in the four countries of the UK in this thesis.

The literature on devolution and health in the UK is dominated by a relatively small cohort of researchers and commentators who in the main are from the fields of health, social or public policy or politics. There is a dearth of literature from the nursing profession. In reports where nursing related issues are cited the viewpoints expressed are generally those of health policy experts rather than direct insight from within the nursing profession, although some studies include feedback from interviews or are informed by dialogue with representatives of professional organisations and trade unions. The outcome may be that where nursing is referred to in the research studies on devolution and health, the perspectives reported may not represent the viewpoints of those from within the nursing profession.

3.2.3 Background to Devolution

One of the commitments of the Labour Government following its election in 1997 was the implementation of constitutional change resulting in the creation of devolved administrations in Scotland, Wales and Northern Ireland. These new legislative bodies were established in 1999, with the NHS and health services being one of the devolved responsibilities (Greer 2004a). The introduction of devolution within the UK was recognised as having the potential for increased diversity in the provision of healthcare (Greer 2001; Jervis and Plowden 2003; Woods 2004) and based on the experiences of other western European countries with similar healthcare systems,

particularly Italy and Spain, there was an increased likelihood that policy development would become a more complex process (Woods, 2004). This potential for increased complexity was linked to a range of factors including the presence of: 'block grants and discretion over their use, the absence of UK-wide monitoring bodies and (varying) degrees of legislative power' between the four countries (Woods 2004, p.324).

At the same time as the introduction of devolution there were unprecedented levels of funding growth for the health services in each of the four countries (Woods 2004), which undoubtedly had a significant impact on the workforce including nursing. Between 1996 and 2006 NHS expenditure per capita⁸ increased by 82% in England, 69% in Scotland, 72% in Wales and 77% in Northern Ireland (Connolly, Bevan and Mays 2010, p.35). The total NHS expenditure in each of the four countries in 2007/08 equated to:

- £83.3 billion or a net expenditure per head of £1,631 in England
- £9.7 billion or a net expenditure per head of £1,891 in Scotland
- £5.3 billion or a net expenditure of £1,772 per head in Wales
- £3 billion or a net expenditure per head of £1,736 in Northern Ireland.

The devolved countries received higher levels of NHS funding per head of population than England (Harker 2012, p.11).

The total UK population in mid 2008 was estimated as being 61.4 million, with 51.5 million in England, 5.2 million in Scotland, 3 million in Wales and 1.8 million in Northern Ireland (Office of National Statistics 2009, p.1).

3.2.4 Overview of the Healthcare Structures and Policy Priorities in each of the Four Countries

This section provides an outline of the different healthcare structures and the related policy priorities in each of the four UK countries following devolution. The information provided for each of the four countries is background information on devolution, details of the level of NHS funding at the time of

⁸ The levels of growth quoted are in cash and do not take account of inflation.

the interviews in 2008, an overview of the changes in healthcare structures and a summary of the key health policy priorities leading up to the interviews.

3.2.4.1 England

In England devolution has not occurred as in the other three countries of the UK. With the exception of the London Assembly; devolution in England has not been progressed. Health matters in England have instead remained under the direction of Westminster legislation and policies.

The NHS Plan: a plan for investment, a plan for reform committed to an 'annual average real terms growth of 6.3%' for the NHS in England, the equivalent to twice the historic growth rate (Department of Health 2000a, p.41).

During 2002, 28 Strategic Health Authorities were established in England replacing the 95 Health Authorities which had previously existed (Moulds 2001). The new Strategic Health Authorities had the remit of managing the local NHS on behalf of the Secretary of State for Health, including delivery of *the NHS Plan*. These were subject to further rationalisation in 2006 when the 28 organisations were consolidated into 10 larger Strategic Health Authorities. At the time of the interviews in 2008, these 10 Strategic Health Authorities were in place in England, providing strategic leadership to deliver improvements in healthcare, including responsibility for workforce planning and development⁹ (Department of Health 2008c).

The overall trends in health policy in England across the period 2000-2008 were for a patient led NHS where 'personalisation' (patient choice and increased control over services) was at the heart of service development and delivery (Department of Health 2001a, 2004a, 2004c, 2005, 2008a); a focus on target driven performance (Department of Health 2000a, 2002a, 2004a)

⁹ In 2004 Strategic Health Authorities merged with Workforce Development Confederations resulting in SHAs taking responsibility for workforce planning and development.

and a shift in care from acute hospitals into community settings (Department of Health 2001a, 2006a, 2008a).

Building upon the internal market¹⁰ which separated the purchase and provision of care; in 2002 the Labour Government in England introduced more radical proposals for competition. This resulted in the new commissioning organisations, Primary Care Trusts and Practice-Based Commissioners (groups of General Practitioners), having the power to purchase healthcare services on behalf of their local population (Department of Health 2002a). This policy of increased competition in England was described by a commentator as redefining the nature of the NHS in England (Woods 2004, p.334), particularly as the policy of active competition was not in place in the other three countries.

England was the only UK country to introduce NHS Foundation Trusts (Department of Health 2002b, 2004a), NHS units with greater local autonomy, increased influence over business and operating decisions including financial flexibility. Foundation Trusts have greater freedom over how services are run including the ability to retain financial surpluses and the facility to borrow funds to invest in patient care and service improvements (Monitor 2010). The creation of NHS Foundation Trusts was aimed at stimulating competition within the NHS in England. Smith described NHS Foundation Trusts as being 'let off the leash' (2007, p.16) as these organisations are not accountable to the Government but are instead accountable to the independent regulator Monitor, which was established in January 2004. As at the 31st March 2008 there were 89 NHS Foundation Trusts in England (Monitor 2008) but only one of these organisations had used its freedoms to implement local pay for its workforce (Staines 2009).

¹⁰ The internal market was the Conservative Government's model of competition introduced in the early 1990s.

3.2.4.2 Scotland

The Scotland Act (1998) resulted in the establishment of the Scottish Parliament and Scottish Administration in 1999. This was followed by the Health Act in 1999 which marked the end of the internal market and competition within healthcare in Scotland.

The publication of *Our National Health: A Plan for Action a Plan for Change* set out priorities for 'rebuilding' the NHS in Scotland with significant increases in funding for health and community care. The £6.7 billion identified for health in 2003-04, represented more than one third of the total devolved budget (Scottish Executive Health Department 2000, p.5).

Trusts were abolished in Scotland in 2004, with responsibility for the planning, commissioning and delivery of healthcare shifting to an increasingly 'centralised hierarchy' (Talbot, Johnson and Freestone 2004, p.6), through the creation of 14 NHS Boards supported by a number of Special Health Boards (Chartered Institute of Public Finance and Accountancy 2008). Community Health Partnerships were also introduced to support the shift in care from acute to community settings (National Health Service Reform (Scotland) Act 2004).

Since devolution Scotland has developed a strong commitment to a new employee relations framework based around 'partnership working' which involves closer working between the government health department, NHS staff and the organisations representing staff (Scottish Office 1998b; Scottish Executive Health Department 1999). The Staff Governance Standard which encompasses the overarching policy for partnership working, employment practice and employee relations became enshrined in legislation through the NHS Reform (Scotland) Act 2004.

Through devolution there has been an increased focus on 'professionally driven' clinical engagement in Scotland (Talbot, Johnson and Freestone

2004, p.6) which has been enabled by the strength of the established medical voice in teaching hospitals and in academia (Greer 2003; Keating 2005a). This power base was attributed to the 'density of professionalists in Scotland, where professional elites have for centuries enjoyed high status and considerable autonomy in their institutions' (Greer 2004a, p.90).

The establishment of Managed Clinical Networks (MCNs) (Scottish Executive Health Department 2000) was a policy intent aimed at increasing the input of clinical experts in the development and delivery of services with a view to implementing best practice across clinical specialties. Managed Clinical Networks were reported to have enabled clinical professionals to also have a greater influence over resource allocation decisions (Davies 2003; Parry 2003). At the time of the interviews in 2008 the professional networks of senior clinicians in Scotland were described '*as being as strong as ever*' (Jervis 2008, p.54).

Following the election on 3rd May 2007, the Scottish National Party (SNP) formed a new minority Government and one of the first actions taken by the new Scottish National Party led Government was the symbolic renaming of the Scottish Executive as the Scottish Government (Trueland 2008a).

3.2.4.3 Wales

The Government of Wales Act in 1998 resulted in the creation of the Welsh Assembly in 1999, whilst the publication of *Putting Patients First* (Secretary of State for Wales 1998) ended the internal market, replacing competition with collaborative working.

One year on from the advent of the Welsh Assembly funding was increased by 9.4% on the previous year, in an attempt to address the reported 'years of under funding' (National Assembly for Wales 2000d, p.5).

Following devolution structural changes encompassing greater lines of accountability were put in place along with a mandate for closer working between Health Boards and Local Authorities (National Assembly for Wales 2001b). At the time of the interviews in 2008 a major re-organisation of the NHS in Wales was being considered which would involve rationalising the 22 Local Health Boards and seven NHS Trusts into seven Local Health Boards and three NHS Trusts. These changes were due to be implemented in 2009.

The initial priorities of the devolved administration included a range of initiatives aimed at addressing NHS capacity and tackling inefficiencies (National Assembly for Wales 2002); promoting closer working between health and social care (Welsh Assembly Government 2003a); improving health and reducing health inequalities (Welsh Assembly Government 2005a). The approach in Wales embodied a 'localist solution' with strong 'community and local authority involvement' (Talbot, Johnson and Freestone 2004, p.6).

3.2.4.4 Northern Ireland

Devolution in Northern Ireland has been intermittent. The Northern Ireland Assembly was formed on 10th April 1998 as a consequence of the Belfast Agreement and the Northern Ireland Act 1998. Although devolution powers were granted on 2nd December 1999 the Assembly was subsequently suspended on 14th October 2002, owing to political issues related to the peace process. Following this there was a tortuous path of events until devolution was finally restored on 8th May 2007.

Northern Ireland is the only country in the UK where Health and Social Care are fully integrated, although this was in place prior to devolution. Following the reinstatement of devolution in 2002, a major review and rationalisation of health and social care was undertaken across Northern Ireland which delivered a reduction in the number of Health and Social Care bodies from 38 to 18. In 2007 further reforms resulted in the creation of five integrated

Health and Social Care Trusts replacing the 18 previous Trusts. The second phase, in April 2009, in response to a Review of Public Administration (Department of Health, Social Services and Public Safety 2009a) will lead to the creation of four new organisations:

- Health and Social Care Board
- Regional Agency for Public Health and Social Well-Being
- Patient and Client Council
- Business Services Organisation.

As highlighted in the Health Policy Chapter (chapter two) of this thesis, health policy activity in Northern Ireland was less than in the other three countries due to the intermittent nature of devolution and focus on restructuring over the period.

The policy priorities in Northern Ireland included reducing health inequalities, promoting health improvement and the management of long-term conditions (Department of Health, Social Services and Public Safety 2004, 2005b), along with the better use of resources and improved efficiencies in the NHS (Department of Health, Social Services and Public Safety 2005a).

The D'Hondt system, specific to the Northern Ireland Assembly, follows the principle 'that seats are won singly and successively on the basis of the highest average'¹¹. The result of the D'Hondt system is that no one political party has overall control of Government and different Ministries are held by different political parties. This model generally requires all party sign up and consequently can result in delays in the policy making process. An advantage of the D'Hondt system is however the engagement of all political parties during the policy making process meaning that in the event of a change in Government the implementation of agreed policies should continue. This was different to the contexts in the Scottish Parliament, Welsh Assembly and Westminster Government where Ministers were appointed

¹¹ <http://archive.niassembly.gov.uk/io/summary/d'hondt.htm>

from the political party or parties in power at that time and where changes in Government often meant that the policies from previous Governments were disbanded and replaced by new policies, regardless of the implementation work that had already taken place. This was due to new political parties implementing the policy commitments aligned to their election manifestos.

3.2.4.5 Summary on the Four Countries

One of the key differences in England, compared with the other three countries was the presence of competition both within the NHS and between NHS organisations and private healthcare providers. This was underpinned by the introduction of Foundation Trusts, and by a focus on patient choice and personalisation which were at the heart of the NHS in England's policy reforms (Jervis 2008).

Wales developed 'localism' which involved the integration of health and local government with a focus on reducing inequalities and improving public health of the local population, as opposed to merely '*treating the sick*' (Greer 2004b, p.4). Scotland had a strong emphasis on partnership working, which more recently had evolved to become a mutual NHS with increased responsibilities for both staff and patients (Scottish Government 2007a). Progress in Northern Ireland has been limited by intermittent devolution, although the integration of health and social care sets it aside from the other three countries.

The healthcare structures and policy priorities in each of the four countries have resulted in different approaches to nursing workforce policy and planning which are reviewed later in this chapter (section 3.3).

The implications of these different policy approaches across the four UK countries were considered in the key informant interviews undertaken in this thesis.

3.2.5 Reserved and Devolved Powers

This section describes the differences between reserved and devolved powers in relation to health and outlines the implications for the four UK countries. It also provides information on the professional regulation of nursing.

3.2.5.1 Overview of Powers

With the instigation of devolution some powers were devolved to the new legislative bodies in Scotland, Wales and Northern Ireland, whilst others remained under the jurisdiction of the Westminster Parliament. Health was reported as being 'the most important service devolved governments have power over' (Ham 2008).

From the outset, devolution has resulted in asymmetrical powers (Leeke, Sear and Gay 2003; Woods 2004; Jeffrey 2007; Jervis 2008), whereby there is variation in the extent of legislative powers between the four countries of the UK. The devolved powers within Scotland and Northern Ireland are more extensive than in Wales and include the right to pass primary legislation. In Wales primary legislation is still set by the Parliament at Westminster, London. The powers within Scotland mean that theoretically it has the potential to abolish the NHS in Scotland (Greer 2004a), although such action is highly unlikely as health policy decisions across the UK are also limited by the 'concept of equity' (Hazell and Jervis 1998), with patients in each of the four countries expecting equitable standards of healthcare provision (Catton 2009).

Overall the Westminster Parliament 'retains full constitutional supremacy' with the power to amend any of the devolution agreements (Paun and Hazell 2008, p.1); therefore devolution is 'in theory reversible' (Leeke, Sear and Gay 2003, p.3). In reality it is implausible that devolution will be reversed and to date the only example of this has been the suspension of devolution in Northern Ireland, with no evidence of any other attempts by Westminster to

change the devolution agreements. The Scottish National Party has had a long standing interest in Scotland becoming independent from the rest of the UK but it cannot hold a referendum on independence without prior authorisation from the UK Parliament (Paun and Hazell 2008). Steps have subsequently been taken to explore public support for Scottish independence with a referendum on the issue planned for 2014.

It was highlighted during the early period of devolution that the Prime Minister, Chancellor of the Exchequer and the Secretary of State for Health in England from the then Labour Government, did little to inform their constituents that their remit in relation to health no longer applied to Scotland, Wales or Northern Ireland (Freeman and Woods 2002). A report on *Devolution and Health*, funded by the Nuffield Trust, identified that *the NHS Plan* (Department of Health 2000a) made little reference to the fact that the policy only applied to England. Furthermore a leaflet outlining details of the *NHS Plan* aimed at the general public, wrongly informed that it was 'for the people of Britain' (Jervis and Plowden 2001, p.21).

A subsequent *Devolution and Health* report in 2008 noted that there had been 'a sharpening of the Department of Health's focus on England', particularly through increased clarity in communications both in the business plan and on the Department's website. The report did however note that there was still 'inevitable interplay' between England and the devolved administrations and it described the 'confusion' which sometimes existed about whether a particular policy was of UK-wide relevance or applicable only to England. It was acknowledged that, on occasion, some UK Ministers appeared keen to 'encourage' this confusion (Jervis 2008, p.90). Additionally, in a survey undertaken on behalf of the Department of Health in England, stakeholders identified that understanding the 'boundaries and hand offs' between the Department of Health in England and the Health Departments of the devolved nations was sometimes a challenge (Jigsaw Research 2009, p.15). Another high profile example of this, within a nursing

context, was when Prime Minister Gordon Brown launched the findings from *Front line care: the future of nursing and midwifery in England* (Prime Minister's Commission 2010). He initially announced that the report set the future vision for nursing and midwifery across the UK, but subsequently clarified that this report was relevant only to England.

These examples highlight the lack of clarity that has persisted following devolution in relation to reserved and devolved powers, particularly between England and the devolved nations. The most likely explanation for these findings is that England, as the largest UK country, was used to leading the policy agenda and the civil servants and politicians within England had not fully understood the implications of working within the context of devolution. Across the period under examination, there was little evidence in the literature that this issue was resolving over time as devolution became more embedded.

3.2.5.2 The Impact of Changes in Government

At the introduction of devolution the Labour party was in power in each of the four countries and this enabled a level of influence into devolved matters which may not be possible in the future (Woods 2002). One area of tension was reported to be Labour's desire to retain a UK-wide National Health Service despite the increased policy variation across the devolved administrations (Greer and Trench 2008). Subsequently, following the elections in 2007, a Scottish National Party minority Government gained power in Scotland, whilst Nationalist Coalition Governments were in situ within Wales and Northern Ireland. In Wales this was a Nationalist and Labour Coalition whilst in Northern Ireland the Coalition was between Nationalist and Unionist parties (Paun and Hazell 2008). These different political arrangements led to increased tensions and the potential for further power imbalances between the devolved administrations and Westminster (Jervis 2008; Royal College of Physicians of Edinburgh 2008), as each of the new governments or administrations began to implement their specific health

policies and associated strategic visions for the NHS within their respective countries. It was reported that the devolved administrations valued 'their ownership of responsibility for their countries' health' (Jervis 2008, p116), however this was within the context of some politicians and civil servants in England trying to promote 'England only' policies across the UK. The resultant impact of this is that since devolution it has been acknowledged that although the core values of the NHS remain intact, it was now considered more appropriate to describe the presence of four national health systems rather than one (Fraser 2008).

3.2.5.3 Professional Regulation of Nursing

Professional regulation is the means by which patient and public safety is ensured through the setting and maintenance of agreed standards for the nursing and midwifery professions (Kirkland 2008). Prior to devolution professional regulation was a matter for the Westminster Parliament and this has continued to be the case following devolution (Secretary of State for Health 2007a, Greer and Trench 2008). Regulation of the nursing and midwifery professions across the UK is managed under the auspices of the Nursing and Midwifery Council (NMC)¹² as outlined in the Nurses, Midwives and Health Visitors Act (1997). The Nursing and Midwifery Council has responsibility for the development of standards for all programmes of pre-registration nurse education, the approval of all providers of these education programmes and for public protection. The existence of UK-wide regulation for nurse education has potential benefits in terms of ensuring continuity for the profession and equity of standards for the public across the UK. Tensions may however arise within the devolved administrations if UK-wide regulation places constraints on country level developments for example the regulation or registration of new nursing roles such as the Community Public Health Nurse, which was under consideration in Scotland (Scottish Executive Health Department 2006a), or Assistant Practitioners¹³ who provide support

¹² The Nursing and Midwifery Council (NMC) replaced the United Kingdom Central Council (UKCC) for Nursing, Midwifery and Health Visiting in 2002.

¹³ Assistant Practitioners may also be referred to as Associate Practitioners.

to Registered Nurses (Department of Health 2006b; Royal College of Nursing 2009).

3.2.6 Mechanisms of Power and Influence

This section examines the different routes of power and influence following devolution, the models of professional nursing leadership in place in each of the four countries and the potential implications for nursing workforce policy and planning.

3.2.6.1 Routes of Influence

One of the findings of the Nuffield Trust's Final Project Report on *the Impact of Political Devolution on the UK's Health Services* was the increased accessibility to government Ministers from 'communities, patients and citizens', particularly within Scotland and Wales (Jervis and Plowden 2003, p.69). Other studies from the Devolution and Constitutional Change Research Programme had similar findings (Keating 2001; Loughlin and Sykes 2004).

This closeness between Ministers and the public was however reported to have adversely influenced the quality of decision making in the devolved administrations resulting in a 'series of tactical responses to immediate local pressures' distorting the strategic direction within countries (Jervis and Plowden 2003, p. 74). An illustration of this was that in the year 2000 during the first six months of devolution in Scotland, there were 1,100 parliamentary questions raised on health related topics compared to the pre-devolution annual total of 1,500 questions to the Scottish Secretary of State in the House of Commons on all matters. Similarly in the period leading up to devolution 'there was only one debate in Westminster on Scottish Health issues', whilst during the first 18 months of the life of the Scottish Parliament there have been approximately 50 debates on health and related matters (Scottish Executive Health Department 2000, p.9). Although such activity

raised the profile of health related issues, it was not clear how priorities were agreed for action.

Devolution was associated with a greater interest from Ministers in micromanaging organisations, resulting in the increased politicisation of healthcare (Greer 2001). This 'increased scrutiny by politicians' in the devolved administrations (Ham 2004, p.111) created opportunities for politicians to learn about issues first hand and to take remedial action. An example of this was during visits to hospitals in Wales in 2007, the Health Minister Edwina Hart spoke to nursing staff in Accident and Emergency Departments who were dissatisfied with how *Agenda for Change*¹⁴ (Department of Health 1999b), the new national pay system, had been applied to their roles. In response to this the Health Minister immediately commissioned an independent review of the implementation of *Agenda for Change* in Wales (Jenkins 2007). This action was taken despite the fact that *Agenda for Change* applied to the majority of NHS staff and the outcomes of this review may have had wider implications for the nursing and non-medical healthcare workforce across the NHS in Wales.

A stakeholder research study undertaken on behalf of the Department of Health in England cited the importance of 'informal as well as formal' interactions in 'building and cementing relationships' but it was also noted that the quality of the engagement was dependent on the efforts of individuals as opposed to the existence of any agreed standards for engagement (Jigsaw Research 2009, pp.27, 28). This highlighted the variability in approaches to influencing Ministers that existed in England.

Devolution also created potential opportunities for nurses to have greater influence on the development of healthcare policy within their constituent countries (Catton 1999) but in order to capitalise on these opportunities nurses required to develop and enhance their political skills (O'Neill 2000).

¹⁴ Agenda for Change was implemented between December 2004 and December 2006.

The review highlighted a lack of evidence to substantiate whether these opportunities for the nursing profession had in fact been realised. In one study it was reported that the Royal College of Nursing in each of the devolved administrations had 'grown and developed' in order to exploit the new opportunities to influence policy but despite this, the overall feedback indicated that professional organisations and clinicians still reported a reduction in their influencing ability, which was at the expense of politicians and civil servants (Jervis and Plowden 2003, pp.60, 64).

Nine years after the introduction of devolution, the importance of nurses acquiring skills in political leadership was reinforced. This was as a means of ensuring that the 'professional voice of nursing' from the devolved administrations was effectively represented at UK level policy debates (Maslin-Prothero, Masterson and Jones 2008, p.669).

Devolution was reported to have resulted in the emergence of distinct roles in different parts of the UK which could have implications for the future mobility of the nursing workforce (Maslin-Prothero, Masterson and Jones 2008). Examples include the Modern Matron role (England), the Community Health Nurse role (Scotland), the different approaches to Nurse Consultant roles and Assistant Practitioner roles across the UK.

The findings from the literature demonstrate that with devolution the routes of power and influence have shifted and that politicians in the devolved administrations are more closely involved in healthcare policy decisions than Members of the Westminster Parliament were before devolution. The limited literature available specifically on devolution and nursing indicates that the nursing profession has not responded well to the opportunities for greater influence created through devolution. This may be due to the profession not feeling empowered to influence health policy development and decision making particularly in the new devolved structures, it may lack the necessary skills and expertise to exert its influence or there may be limited capacity.

3.2.6.2 Models of Professional Leadership in the Four Countries

In this section the models of professional nursing leadership in each of the four countries are summarised to provide background information and context in relation to decisions on nursing workforce policy and planning matters. Prior to devolution there was a Chief Nursing Officer employed in the health departments in each of the four countries. Although this has remained the case following devolution, differences have emerged in the models of professional nursing leadership within the devolved administrations.

In Wales the Office of the Chief Nursing Officer merged with the Office of the Chief Medical Officer to form the Department of Public Health and Health Professions, resulting in the Chief Nursing Officer reporting to the Chief Medical Officer. Whilst this arrangement has likely benefits for inter-professional working this subordination to medicine is something the nursing profession has strived hard to relinquish (Chiarella 2002; Davies 2002). This new arrangement has the potential to re-enforce the inferiority of the professional nursing voice, in comparison to medicine, within Wales.

Professional leadership in Northern Ireland was provided by means of a Chief Nursing Officer within the Department of Health Social Services and Public Safety. The Regional Agency for Public Health and Social Well-Being, established in 2009, also includes a Nursing Director on its Board but it is not clear why there was no readily identifiable professional nursing leadership position on the new Health and Social Care Board.

Over the period 2004-2009, the Chief Nursing Officer in Scotland also held the post of Director of Workforce, which has responsibility for human resource issues across the whole workforce in NHSScotland. This joint appointment could be viewed by nurses, professional nursing organisations and trade unions as a dilution of the Chief Nursing Officer role in Scotland,

however an alternative perspective is that there could be positive implications for the nursing workforce due to the professional lead also holding strategic responsibilities for the wider healthcare workforce, including the functions of nursing workforce planning and development. There was therefore an increased likelihood that under this model of leadership, nursing would be given full consideration when workforce policies were being developed. This dual role has only been held by one Chief Nursing Officer in Scotland and it was created to match the personal skill set of the individual post holder.

The Chief Nursing Officer role in the Department of Health in England remained largely unchanged over the period of this research.

These different models of professional nursing leadership and their impact in relation to nursing workforce policy and planning will be considered further during the analysis of interview data and reporting of findings chapter of this thesis (chapter six).

3.2.7 Policy Divergence across the Four Countries

3.2.7.1 Overview of Health Policy Divergence

This section focuses on the nature and extent of health policy divergence between the four countries of the UK. Divergence in health policy existed prior to devolution however this has increased since devolution (Sullivan 2002). The creation of the devolved administrations has been described as a UK 'policy laboratory' (Freeman and Woods 2002, p.463) and as 'a natural experiment in the consequences of decentralisation', with resultant divergence in relation to health policies (Greer 2003, p1). As the devolved structures have become more established, health policies have developed to meet the specific needs and priorities of each country and the populations served, whilst providing opportunities for innovation (Leeke, Sear and Gay 2003). This increased divergence has resulted in the emergence of 'the UK's family of health systems' as opposed to a single UK NHS (Jervis and Plowden 2003, p.9). Furthermore Greer cautioned that, in light of this

increased policy divergence, if the NHS is to remain 'national' then the nations will be from the individual country perspectives of England, Scotland, Wales and Northern Ireland as opposed to Great Britain (Greer 2003, p.3).

Greer described the 'zenith of divergence' between the four UK countries as being in 2004, following which he reported that differences in policies began to settle down, although he did acknowledge that there was the potential for major differences in the future as a consequence of changes in the Government within any of the countries, alterations to the Barnett formula which determines funding allocations for public spending or the possible introduction of independence within Scotland (Greer 2009, p.24). The researcher does not agree with Greer's finding that the 'zenith of divergence' was in 2004, particularly given that the Scottish Government is actively promoting full independence (Scottish Executive 2007a) and given that following the change of UK Governments in 2007, there was a further drive for greater decentralisation (Paun and Hazell 2008) and continued divergence in health policy in the devolved administrations (British Medical Association 2010).

Wood's analysis of the impact of devolution of the UK's health services highlighted the situation whereby the devolved administrations used their powers to 'resist and reject' English healthcare policy (2004, p.337). A study undertaken by the Economic and Social Research Council (2005) reported a similar finding when it postulated that the policy divergence in Scotland was driven primarily by its desire to implement different policies than England, as opposed to pursuing local innovation. Another perspective was offered by Keating who considered that the policy making style in Scotland was more 'consensual and negotiated' (2005b, p.6). This latter view is supported by the development of Managed Clinical Networks and the culture of partnership working in place in Scotland. Additionally this 'rejection' of English policy could be interpreted as the devolved administration in Scotland exploring its

new freedoms and responding to local priorities through its strong clinical and professional networks.

The priority focus of Welsh health policy was on improving the public health of its population (Greer 2004a; Lang 2007). There were however similarities between the Governments in Wales and Scotland, who were both opposed to the culture of competition amongst healthcare providers actively promoted by the Westminster government (Greer 2006).

Another view, put forward by Ham (2004); Jervis (2008) and Moore (2009) is that rather than divergence being principally in the devolved nations, the greatest evidence of divergence and innovation in health policy had in fact emerged from England particularly during the second term of the Labour Government, which was demonstrated through the increased use of the private sector in healthcare; the patient choice agenda and the introduction of Foundation Trusts. A further influencing factor was that despite the decentralised approaches taken in the devolved administrations, the most significant power base in the UK resided with England principally due to its sheer size relative to the other three countries.

3.2.7.2 Reasons for Divergence

The policy divergence between the four UK countries was attributed to the existence of well developed and highly influential policy communities in each country (Greer 2004a). The tight knit political and professional networks in Scotland and Wales described as 'policy villages' (Jervis and Plowden, 2003) were acknowledged as being critical to achieving consensus on both policy and strategy, whilst the small size of these countries was recognised as being important in aiding policy implementation (Constitution Unit 2001).

Five years after the introduction of devolution a commentator noted that policy makers in the devolved administrations appeared to be more interested in actively pursuing different policy agendas focused on 'national

insularity' rather than 'learning from the differences that have emerged' (Ham 2004, p.112). The researcher argues that policy makers in Department of Health, England were just as insular in their approach as there was a lack of evidence of England adopting innovations from the devolved administrations. As highlighted in section 3.2.7.1, greater innovation in health policy was reported in England compared to the devolved administrations (Jervis 2008). It was noted however that despite the acknowledgment of the differences in public policy across the UK, little attention was being focused on addressing the impact of this (Institute of Public Policy Research 2008).

A subsequent report identified that the devolved administrations were generally not receptive to learning the lessons following implementation of policies in England and this was attributed to 'political barriers' (Bell 2010, p.80). The researcher agrees with this assessment particularly in the context of the attempts by England to dominate the health policy agenda. A factor contributing to this position is that the devolved countries had several years experience of developing health policies in line with the needs of their local populations and therefore the lessons from England on health policy implementation may no longer be relevant.

3.2.7.3 Implications for Nursing Policy

This section considers the implications of devolution specifically on nursing policy divergence. Jervis and Plowden (2003) reported that the divergence across the four UK countries was most noticeable in terms of organisational structures and policy making processes rather than in actual policy content. However a detailed analysis conducted for this thesis presents a different perspective. The researcher does not agree with Jervis and Plowden's assessment as there was evidence of nursing policy divergence across the UK following devolution. Specific examples of this policy divergence within nursing include:

- graduate level pre-registration programmes for nursing were already in place in Scotland, Wales and Northern Ireland for several years before

the introduction of the new UK wide Nursing and Midwifery Council standards mandating that all programmes be at graduate level by September 2013 (Nursing and Midwifery Council 2010)

- the different responses to the staging of the 2007 national NHS pay award whereby nurses in Scotland, Wales and Northern Ireland received a 2.5% pay award, whilst nurses in England received 1.9% (Trueland 2007; Trueland 2008b; Moore 2009)
- as noted before, the emergence of different nursing roles in different countries for example the Modern Matron role in England (Department of Health 2000a, 2001b); the pilot of a new Community Health Nurse in Scotland (Scottish Executive Health Department 2006a) and the range of models for the Family Health Nurse (Scotland), Family Nurse (Wales), Family Nurse Partnership (England) roles across the UK (MacDuff and West 2005; World Health Organisation 2006; Barnes et al. 2008)
- different approaches to Healthcare Support Workers and Assistant Practitioner roles (Royal College of Nursing 2007a and 2009), including the pilot of employer led registers in Scotland (Scottish Government 2009).

The Head of the Royal College of Nursing in Scotland acknowledged the value of gaining insight into the different healthcare perspectives and learning from the experiences in the other parts of the UK, which she emphasised was consistent with the ethos of devolution (Fyffe 2008, 2009); however the researcher identified a lack of evidence to substantiate if this learning from good practice had taken place across the UK.

Another issue was the role of UK-wide regulatory bodies and the Department of Health in England when representing the UK professional viewpoints on European and international matters (Jervis 2008). Maslin-Prothero, Masterson and Jones (2008) highlighted that these organisations needed to ensure that an up to date policy position from each of the four countries was

accurately represented in UK-wide discussions, with adequate staffing resources in place to support functions across the four countries. Between the introduction of devolution and the interviews undertaken for this thesis in 2008, there were no noticeable changes to the structures of the Nursing and Midwifery Council, the UK wide regulatory body for nursing and midwifery. Greer and Trench also cited continued challenges for UK-wide organisations *'because the line between professional regulation – which is a reserved power – and health services policy, which is largely devolved, is not clear'* (2008 p.35).

3.2.8 Gaps in the Evidence Base on Devolution

As highlighted earlier in this chapter there is a relative lack of research into devolution's impact upon the healthcare workforce, particularly nursing as the single largest professional group in the NHS. Although there are published articles explaining what political devolution means for nurses (including Catton 1999; Maslin-Prothero, Masterson and Jones 2008; Fyffe 2008) there are no known research studies on the impact of UK devolution on nursing workforce policy and planning. There is also an apparent lack of recognition of the need for research to be undertaken in this area.

3.3 Nursing Workforce Planning

3.3.1 Introduction to Workforce Planning

Workforce planning is the process by which the future supply of the workforce is determined. It encompasses having the right number of staff, with the right skills and competencies, in the right location to meet the direct and indirect care needs of patients. Workforce planning has been summarised as consisting of three main elements:

1. 'assessing how many, and what type, of staff are required (demand side)
2. identifying how many of these staff will be supplied (supply side)
3. determining how a balance between demand and supply side can be achieved' (Buchan 2007).

The researcher considered this to be quite a narrow, technical definition of workforce planning which does not take account of the implications of broader policy. Health policies can have a significant impact on determining future workforce requirements (demand) through changes in clinical treatment or care delivery, whilst wider policies for example those relating to pension reform or workforce migration can directly influence workforce availability (supply). This broader description of workforce planning, including the impact of health policies on workforce supply and demand, informed the researcher's approach and will be examined further in this study.

Prior to devolution responsibility for healthcare workforce planning resided with the government health departments in each of the four countries and following devolution this position remained unchanged. Each country has developed its own workforce planning processes and infrastructure to meet local needs. Workforce planning activity is mainly focused on the NHS workforce in part because it is difficult to obtain accurate data on both the existing workforce and future requirements of non NHS organisations. The complexity of undertaking workforce planning for the NHS workforce has been acknowledged (House of Commons Health Committee 2007a, 2007b). There are several factors contributing to this complexity including the size of the NHS, the number and diversity of the organisations within it, the constantly evolving healthcare treatments, the range of different healthcare professions and the lead in time, from four to fifteen years, to train staff for these professions.

Additionally the economic considerations of effective workforce planning are vast with 70% of NHS funding being spent on staffing (Scottish Executive Health Department 2002a; House of Commons Health Committee 2007a). There is also a patient safety and clinical risk issue if adequate numbers of Registered Nurses are not available in the workforce (Aiken et al. 2002;

Clarke and Aiken 2006; Rafferty et al. 2007). Furthermore increased demands are placed on the existing workforce and high levels of unfilled vacancies can lead to the use of short term staffing solutions for example agency nurses, which is generally a high cost and non-sustainable option (National Audit Office 2006).

Over the period of this research and since devolution was introduced, there has been considerable focus on workforce planning activity across the NHS. The sections below provide an overview of the health workforce planning structures, the key policies and reports on workforce planning and the action taken in response to these. This information is provided for each of the four UK countries and includes the chronology to the structural changes over the period of the study along with a summary of the workforce planning structures in place at the time of the interviews in 2008.

3.3.2 Workforce Planning Reports, Policies and Structures in the Four Countries

3.3.2.1 *England*

The House of Commons Health Committee inquiry into workforce planning in England in 1999 identified a number of issues including: 'disturbing staff shortages in the NHS' (1999a, para 62), with targets for nursing growth based on affordability rather than service requirements, significant deficiencies in workforce planning systems including a lack of integration between medical and non-medical planning and a failure to take account of service planning. The conclusions of this report stressed the need for the Government to urgently reassess its nurse staffing projections and undertake a review of current workforce planning systems.

One year later *the NHS Plan* (Department of Health 2000a) was published setting a target of 20,000 additional nurses by 2004, to address the shortages cited by the inquiry (Department of Health 2000b). The Government's commitment to undertake a major review of workforce

planning (Department of Health 1999c) resulted in the publication of *A Health Service of all the talents: Developing the NHS Workforce* (Department of Health 2000c). This consultation acknowledged the need for improved integration of workforce and service planning together with increased clarity of responsibilities and accountabilities and improved performance management systems. It emphasised the importance of both local ('bottom up') and central ('top down') planning, which it proposed would be achieved through the creation of 28 Workforce Development Confederations and a National Workforce Development Board.

The Workforce Development Confederations were given responsibility for leading integrated workforce planning, championing workforce development and tackling recruitment and retention challenges within their local areas. Following their establishment in April 2001, the Workforce Development Confederations merged with Strategic Health Authorities in April 2004, essentially making them a workforce and human resources directorate of the Strategic Health Authority (Foster 2006a). In 2006 the Strategic Health Authorities were subject to further reorganisation when the 28 organisations were rationalised down to ten.

In 2006 another House of Commons Health Committee inquiry was convened to review the effectiveness of NHS workforce planning in England, particularly in light of the re-emergence of 'boom-bust cycles' of workforce supply (House of Commons Health Committee 2007a, p.6). This was at a time when nursing posts were being cut and newly qualified nurses had difficulty securing employment, whilst a few years before there had been a perceived shortage of nurses and associated national growth targets. The findings of this inquiry were highly critical and included reports of 'a disastrous failure of workforce planning' focused on short term priorities and undertaken in professional silos (p.3). It described 'an appalling lack of coordination between workforce and financial planning' (p.3); large increases in pay awards to staff without any associated return in productivity; a lack of

skilled personnel to undertake workforce planning and the low importance placed on this function by NHS managers. It identified that new policy initiatives did not always 'include a clear analysis of related workforce requirements' (p.98). The disconnect between the requirements of service and education commissioning was also highlighted along with the need to use education and training to develop increased flexibility within healthcare roles.

The Committee criticised the Department of Health for its failure to ensure that the levels of workforce growth were consistent with available funding, principally due to the fact that the nursing workforce growth delivered was 340% higher (2007a, p.13) than the 20,000 target set in *the NHS plan* (Department of Health 2000a). It concluded that 'despite great efforts in some quarters, the workforce planning is not performing noticeably better than 8 years ago' when the previous House of Commons Health Committee review was undertaken (2007a, p.51). It was however recognised that the successive re-organisations within the NHS in England had not been helpful and therefore it was recommended that Strategic Health Authorities retained responsibility for workforce planning and education commissioning.

The *NHS Next Stage Review* (Department of Health 2008a, 2008b) was tasked with addressing the issues raised in the 2007 House of Commons Health Committee report. The *NHS Next Stage Review's* recommendations on workforce planning and education supported further devolvement of decision making; increased clarity of roles and responsibilities and improved integration of workforce and service planning. There was recognition of the importance of renewed system leadership and management which it sought to address through the creation of two new organisations Medical Education England and the Centre for Workforce Intelligence¹⁵.

¹⁵ CfWI replaced some of the functions of the Workforce Review Team which undertook workforce risk assessments and provided workforce intelligence for the health professions in England.

Despite the criticism in the 2007 House of Commons Health Committee report leveled at the lack of integration between medical and non-medical workforce planning, the *NHS Next Stage Review* did not fully address this as the new body Medical Education England only had a remit for medical, dental, pharmacy and healthcare science professions but excluded nursing; despite this being the largest professional group in the NHS. The fact that the *NHS Next Stage Review* was led by an eminent surgeon and included strong medical involvement in its programme of work was likely to have influenced this outcome.

The above summary provides the history and context to the issues and challenges associated with nursing workforce planning in England over the period under review. At the time of the interviews in 2008, there were ten Strategic Health Authorities in England, each with responsibility for leading the assessment of local workforce needs in partnership with NHS Trusts and Foundation Trusts (providers of healthcare) and Primary Care Trusts (commissioners of healthcare). The Strategic Health Authorities were also responsible for developing education commissioning plans to determine the number of places required on non-medical pre-registration programmes annually.

At a national (England) level, the National Workforce Review Team was responsible for producing annual healthcare workforce intelligence reports, including risk assessments for the main clinical staff groups. These reports were provided to support Strategic Health Authorities with the development and review of workforce plans. These workforce plans were then used to inform the education commissioning plans.

In addition to the Strategic Health Authorities, there was a Department of Health Workforce Programme Board with the remit of reviewing and overseeing the delivery of workforce strategy across England (House of Commons Health Committee 2007b).

The significant impact of the lack of integration between financial and workforce planning was outlined in a subsequent review undertaken in 2009, on behalf of the Department of Health, which illustrated that if the NHS in England was to achieve the required £20 billion savings by 2014 then 137,000 posts needed to be cut (McKinsey and Co 2009). This equated to 10% of the NHS workforce in England and was estimated to include the loss of ten nursing and ten healthcare support worker posts per acute hospital, along with other members of the multi-professional team (Gainsbury 2009a). Savings were calculated based on improved efficiency and productivity and included a suggested loss of 1,600 district nurses (Gainsbury 2009b), which was against the backdrop of a number of healthcare policy drivers advocating a shift in care from acute hospitals into community settings, as detailed in the health policy analysis section of this thesis (chapter two).

In 2009 The King's Fund (an independent health policy '*think tank*') carried out a review to establish the extent to which NHS workforce planning in England was 'fit for the future' (Imison, Buchan and Xavier 2009, p vii). It acknowledged the complexity of workforce planning for the NHS and concurred with the shortcomings identified in the previous House of Commons Health Committee reports, whilst making recommendations for further improvements.

3.3.2.2 Scotland

In Scotland an increased focus on workforce planning and development was seen as key to achieving the workforce required to modernise the health service (Scottish Executive Health Department 2000 and 2002a). The infrastructure established to support this included the creation in 2002 of a new Special Health Board NHS Education for Scotland (NES); three regional networks each headed up by a Regional Workforce Director; a National Workforce Committee responsible to the Management Board of the Scottish Executive Health Department and a National Workforce Planning Unit.

(Scottish Integrated Workforce Planning Group 2002; Scottish Executive Health Department 2002a and 2002b). The *Partnership for Care* policy clarified responsibilities for workforce planning, made commitments that workforce development would be 'at the heart of health policy' and confirmed that more resources would be made available for workforce planning and development (Scottish Executive Health Department 2003b, p.9).

The NHS Reform (Scotland) Act (2004) made it a statutory responsibility for NHS Boards in Scotland to carry out workforce planning. This was referred to by the Royal College of Nursing (Scotland), as a Royal College of Nursing sponsored amendment to the NHS Reform (Scotland) Bill due to the extent of campaigning undertaken to have this clause included (Royal College of Nursing 2006; Griffiths 2006). Following this the Royal College of Nursing in Scotland called for secondary legislation which would require NHS Boards to 'establish a staffing system that provides the right number of registered nurses to ensure appropriate staffing levels for patient care' (Royal College of Nursing Scotland 2005, Royal College of Nursing 2006). This was at a time when the Royal College of Nursing was actively campaigning for minimum nurse staffing levels to be introduced in Scotland (British Broadcasting Corporation 2004). Subsequently the drive for this policy approach from within Royal College of Nursing in Scotland appeared to wane which also coincided with a change of senior leadership in the organisation. This resulted in a subtle change in language to a call for 'a legal duty on NHS Boards to put mechanisms in place to ensure safe and appropriate staffing levels' (Royal College of Nursing Scotland 2007, p7).

In order to drive a more multi-professional approach to workforce planning, the National Workforce Planning Framework (Scottish Executive Health Department, 2005c) was introduced resulting in the publication of an annual National Workforce Plan for NHSScotland, from 2006 onwards.

In 2005 the Health Committee of the Scottish Parliament published its findings following an inquiry into workforce planning in the NHS in Scotland. The Committee reported that: 'there has been little effective strategic workforce planning within the NHS in Scotland' whilst 'little attempt was made . . . to match the supply of potential NHS staff with demand' (Scottish Parliament Health Committee 2005, p.2). It acknowledged the new systems and infrastructure recently established by the Scottish Executive Health Department but raised concern that responsibility for workforce planning would be spread across 'three tiers of management' which were local, regional and national (p.4). This concern was substantiated two years later when Audit Scotland reported that workforce development strategies were still not fully integrated with service planning (Audit Scotland 2007). The new Scottish Government sought to address this through the requirement for Local Delivery Plans to include finance and workforce information (Scottish Government 2007b).

At the time of the interviews undertaken for this thesis in 2008, there were three regional workforce planning networks in Scotland (North, East and West), to support local workforce planning and workforce development activity. The Student Nurse Intake Planning (SNIP) process, introduced in 1996, was the national methodology used to inform annual pre-registration nursing commissioning decisions. This was a 'bottom up' planning process which was used workforce planning information from NHS Boards. This process was overseen by the National Workforce Planning Unit and included wide stakeholder engagement. At the end of the process the Minister for Health 'signed off' the final education commissioning plan each year.

3.3.2.3 Wales

Following devolution in Wales a new workforce planning process was introduced, supported by an electronic Human Resource system. In addition to this any organisation or professional group experiencing staffing shortages

was given specific responsibility for the development of a recruitment and retention plan by September 2001 (National Assembly for Wales 2001a).

Despite this intervention a subsequent review of Health and Social Care in Wales, overseen by Derek Wanless, identified several concerns in relation to workforce planning including:

- a lack of workforce planning capacity
- the validity of workforce data
- workforce planning driven principally by affordability
- the need for more sophisticated approaches to workforce planning
- workforce planning being undertaken in isolation from service and financial planning
- the timeframes for workforce planning were inconsistent with the delivery of some policy initiatives, resulting in challenges ensuring the required workforce was in place.

In addition to addressing the above issues, recommendations of the *Wanless Review* included the need for strong centralised leadership; an evaluation of the workforce planning mechanisms in place at the time and greater consideration to be given to 'lead in times' to enable the delivery of future workforce requirements with the relevant education and training. It also emphasised that workforce planning needed to have a longer term view over a period of 20 years and be incorporated as part of an integrated health and social care strategy (Welsh Assembly Government 2003a).

In an attempt to rectify these issues a proposal was developed to establish a Workforce Development, Education and Commissioning Unit (WDEC) as part of the National Leadership and Innovation Agency for Healthcare (NLIAH) (Welsh Assembly Government 2005b). This was aimed at improving workforce development, encompassing workforce planning, and was seen as the solution to meeting the specific needs of the Welsh population (Welsh Assembly Government 2005b).

Three years after the Wanless Review, an inquiry into Workforce Planning in Health and Social Care was undertaken and its findings again outlined a lack of workforce planning capacity, both centrally and in local NHS organisations, and the fact that workforce planning was based on historical patterns rather than reflecting the needs of changing healthcare delivery in Wales (National Assembly for Wales 2008). Recommendations included the introduction of integrated workforce planning systems, an increase in workforce planning skills at the Workforce Development, Education and Commissioning Unit and the need to address deficits in workforce planning capacity in Local Health Boards. It also proposed to enhance specialist community nursing capacity, through tailored education and training, to deliver the strategic vision for improved health and social care as outlined in *Designed for Life* (Welsh Assembly Government 2005a). In the summary of the report mention was made of the need for the closer integration of medical workforce planning with that for other health professionals but there was no specific recommendation to address this matter.

At the time of the interviews undertaken for this thesis in 2008, guidance was published detailing the proposals for a new planning framework integrating workforce with service and financial planning. It also clarified responsibilities for national and local workforce plans, including employer operational development plans (National Leadership and Innovation Agency for Healthcare 2008a, 2008b).

The Workforce Development, Education and Commissioning Unit was the lead organisation at a national level but it was acknowledged by the Welsh Assembly Government that it needed to have a close relationship with local workforce planning systems (2005b).

3.3.2.4 Northern Ireland

In Northern Ireland the Acute Services Review (Department of Health, Social Services and Public Safety 2001) and the Human Resources Strategy (Department of Health, Social Services and Public Safety 2002b) highlighted the need for greater emphasis on workforce planning both within and across professions. A report by KPMG in partnership with the Department of Health, Social Services and Public Safety estimated that over the period 2002-2006 there would be a shortfall of 2,799¹⁶ in the nursing workforce. Additionally it was suggested that there should be 'significant investment' to support increased numbers of Healthcare Support Workers at National Vocational Qualification (NVQ) level three to augment the nursing team (Department of Health, Social Services and Public Safety and KPMG 2002, p.15).

A subsequent comprehensive review of the nursing and midwifery workforce identified that the increased numbers of pre-registration commissions, instigated in response to the earlier report, had impacted positively on the supply of nurses, nevertheless further areas for improvement were raised and these included an increased focus on:

- embedding workforce planning activity in local healthcare organisations
- reducing attrition from pre-registration programmes
- gaining a greater understanding of the impact of a range of policies and initiatives on the nursing workforce
- developing specific strategies to address recruitment and retention, workforce modelling and skill mix (Department of Health, Social Services and Public Safety 2005c).

The implementation of the recommendations was overseen by the Central Workforce Planning Group. A Workforce Planning Unit (WPU) was also established within the Department of Health, Social Services and Public

¹⁶ It is not clear if this figure relates to full time equivalent (FTE) or head count. If it is FTE then the number of nurses required to meet the shortfall will be higher as some staff work part-time hours.

Safety, with the remit to carry out workforce reviews across the healthcare professions, including supply and demand modelling to inform the annual education commissioning cycle. This infrastructure was in place at the time of the interviews undertaken for this thesis in 2008. The Department of Health, Social Services Public Safety committed to carrying out a full review of the nursing workforce every three to four years supplemented with an annual update but despite this agreed programme of reviews, the last published full-scale review of the nursing workforce appeared to have been undertaken in 2005. Subsequent to the interviews a summary review of the Nursing and Midwifery workforce was published in 2009 (Department of Health, Social Services Public Safety 2009b).

The challenges experienced in relation to nursing workforce planning in Northern Ireland were broadly consistent with those identified in the other three countries; however there has not been a Health Select Committee or similar scrutiny group remitted to review workforce planning in Northern Ireland. The reason for this could be the immaturity of the political structures within Northern Ireland and the perceived importance of NHS workforce planning in comparison to other matters.

3.3.2.5 Summary on Workforce Planning Reports, Policies and Structures

In summary each of the four countries had developed different approaches to nursing workforce planning, all of which were used to inform the numbers of education commissions placed for pre-registration nursing programmes annually.

This overview of the key workforce policy documents from each of the four countries provided the chronology to the workforce policy and planning activity which had occurred over the period under review in this thesis. The structures in place in each country at the time of the interviews in 2008 were also highlighted.

There were a number of consistent themes and issues in relation to nursing workforce planning which each country was trying to address for example: better integration between workforce, finance and service planning; enhancing workforce planning capacity; increased clarity regarding responsibility for nursing workforce planning along with initiatives to develop multi-professional workforce planning. Although each country had taken different approaches to these issues it was not clear which had been the most effective. These different approaches were explored further during the interviews undertaken in this thesis.

3.3.3 Nursing Workforce Planning Initiatives and Tools

At the time of the interviews in 2008 work was underway in England and Scotland to develop tools to measure nursing workload to inform workforce plans at a local organisational level. This section provides background information on how and why these workstreams were established and the progress that had been made. The work in both countries was initiated in response to reviews of nurse staffing undertaken by audit bodies.

The Audit Commission's *Acute Hospital Portfolio Review of Ward Staffing* (2001a) revealed significant variations in expenditure on ward staffing related to nursing numbers, skill mix and the use of temporary staffing in different hospitals in England. Following publication of this report, the Department of Health commissioned a systematic review of the workforce planning systems used to inform the composition of nursing establishments, with the explicit aim of helping nurses 'make better decisions about cost-effective numbers and mixes of nurses'. In addition to this it was reported to help nurses 'make sense of the complex and uncertain world of nursing workforce planning' (Hurst 2002, p.5).

A further audit review undertaken in 2005 identified that although several Trusts had developed workload measurement tools, none of these tools

provided consistent results when applied across organisations (Commission for Healthcare Audit and Inspection 2005). Subsequent work was undertaken to develop a nursing workforce planning tool for acute care areas through the Association of United Kingdom University Hospitals (AUKUH 2007). There was however no requirement for organisations in England to use any workforce planning tools; instead these decisions were left to local NHS organisations to determine how to assess their nurse staffing requirements. This was in line with the devolved responsibility for workforce planning in England, including the increased freedoms available to NHS Foundation Trusts.

In 2002 an independent assessment of nursing workforce planning was undertaken in a sample of hospital wards across all Trusts in Scotland, culminating in the publication of the report *Planning Ward Nursing – legacy or design?* (Audit Scotland 2002). The findings of this study highlighted major limitations in nursing workforce planning including a lack of dedicated resources for this function, with just 16 full time equivalent (FTE) staff identified to support workforce planning across the whole of the NHS in Scotland (p.4). Unexplained differences in nursing establishments and variations in ratios of Registered to Non Registered nurses were found in similar types of wards and there was no relationship between expenditure on ward staffing and quality of care, based on proxy quality indicators.

In response to the Audit Scotland report, The *Nursing and Midwifery Workload and Workforce Planning Project* (Scottish Executive Health Department 2004a) was established which resulted in a series of recommendations to ensure consistent processes and standards for nursing workforce planning across all care settings and specialties in NHSScotland. This programme of work culminated in nationally agreed tools for assessing nursing workload and workforce planning being developed and implemented across NHSScotland (Scottish Executive 2007b).

In 2007 Audit Scotland undertook a follow up review of its original 2002 report *Planning Ward Nursing – legacy or design?* This acknowledged that good progress had been made in addressing the recommendations identified in its earlier study and it supported continued work on the implementation of nursing workload measurement tools (Audit Scotland 2007).

The different approaches taken to the assessment of nurse staffing requirements in England and Scotland were in line with the way other healthcare policies and related initiatives have been implemented in both countries. For example the *Nursing Workload and Workforce Planning Project* was a workstream of the Scottish Executive Health Department which involved all NHS healthcare organisations in Scotland, whilst the work to develop workforce planning tools in England was being driven by a small group of professional experts and enthusiasts, with Trusts choosing if they wished to be involved.

3.3.4 Summary of Key Themes from Workforce Planning Literature

This thesis is focused on the period 1997-2009. In 1997 the new Labour Government was elected across all four countries of the UK and the following year legislation was passed resulting in the introduction of devolution in Scotland, Wales and Northern Ireland during 1999. This thesis is concerned with gaining a greater insight into the impact of UK devolution on nursing workforce policy and planning by examining the systems, structures and policies in place prior to the introduction of devolution and over the decade that followed through to 2009.

Over the period covered by this thesis, workforce planning in the NHS has been the subject of four Health Committee reviews, two in England, one in Scotland and one in Wales (House of Commons Health Committee 1999a, 1999b; House of Commons Health Committee 2007a, 2007b; Scottish Parliament Health Committee 2005; National Assembly for Wales 2008). A range of policies and reports have also identified shortcomings in NHS

workforce planning systems across the UK (including Buchan and Edwards 2000; Audit Commission 2001a; Audit Scotland 2002; Finlayson et al. 2002; Buchan 2004; Buchan 2007; Audit Scotland 2007; Imison, Buchan and Xavier 2009).

The findings of these reviews and reports have highlighted consistent themes both within and across countries including:

- the need for greater clarity of responsibility and accountability for workforce planning
- substantial gaps in workforce planning capacity and capability
- the respective merits of centralised versus local workforce planning
- lack of integration between service, financial and workforce planning
- the need for better integration between workforce planning for medical and non medical professions.

In an attempt to improve workforce planning each country designed and implemented its own independent systems with differing levels of success. At the time of the interviews for this thesis in 2008, England was focused on the devolvement of workforce planning with responsibility for this discharged through the ten Strategic Health Authorities, under the guidance of the Workforce Directorate at the Department of Health.

In Scotland, Local Delivery Plans integrating service and workforce planning were being developed through the three regional planning networks. Additionally national work was underway to ensure nursing workforce planning was being taken forward on a consistent basis and integrated with the planning for other professional groups, through the nationally agreed workforce planning process led by the National Workforce Unit.

Wales was in the process of implementing a new workforce planning framework aimed at improving the integration of workforce, financial and service planning and clarifying national and local responsibilities supported

by the National Leadership and Innovation Agency for Healthcare, whilst the system in place within Northern Ireland was centrally driven through the Department of Health, Social Services and Public Safety with support from external consultants for major workforce reviews. Owing to the intermittent nature of devolution and the wider national priorities in Northern Ireland, workforce planning infrastructure and systems were not as well developed there.

Specific work on nursing workforce planning tools was underway in both England and Scotland but the approaches in the two countries were quite distinct, with England leaving decisions on the use of tools to local healthcare organisations, whilst all NHS organisations in Scotland were required to use the tools and progress with this implementation was monitored centrally. The approach taken in Scotland ensured that NHS organisations utilised evidence based methods to determine nurse staffing requirements and this use of consistent tools supports benchmarking across similar specialties or organisations. In England the more laissez faire approach to the use of tools gave organisations the freedom to develop solutions to meet the needs of their patient population and service delivery models but it also allowed organisations to 'opt out' of using any tools, this was similar to the position in Wales and Northern Ireland where there was no clear evidence in the literature of work in place to promote the specific use of nursing workforce planning tools.

Each of the four countries undertook workforce planning activities to address the needs of each respective country, in line with its specific healthcare strategies and policies but there was little evidence, in the literature, of any work in relation to integrated nursing workforce planning across the four countries. This was despite the fact that Registered Nurses in the UK workforce have the freedom to work in any one of the four countries and shortages in one country could impact upon the supply in another.

3.3.5 Gaps in the Nursing Workforce Planning Evidence Base

The literature on workforce planning systems in the UK has generally been reported in a negative context or from a negative viewpoint, whereby deficiencies or shortcomings of the processes in place to support this function have been highlighted. There has been a history of 'boom and bust' funding which has impacted upon nursing workforce planning and resulted in challenges in balancing the requirements of having sufficient staff with the necessary education and skills to provide optimal patient care, whilst also managing the episodes of potential oversupply of the nursing workforce.

In reviewing the evidence across the four UK countries, the researcher concluded that workforce planning (including nursing workforce planning) is an extremely complex function which has been subject to frequent review and reform, however despite several high level reviews and associated recommendations for change, there was little evidence of any noticeable improvements in nursing workforce planning rather there were repeated references made to the same failings. Neither was it clear from the literature which planning strategies, if any, had been the most effective in terms of delivering the required nursing workforce.

There were a number of factors which contributed to this position including the limited skilled resources available to support workforce planning, the dominance of financial planning and the low importance placed on the workforce planning function in comparison to achieving financial balance (House of Commons Health Committee 2007a). The excessive nursing recruitment in England over and above the targets set in *the NHS Plan* and *Delivering the NHS Plan* (Department of Health 2000a, 2002a) was condemned in the House of Commons Health Committee report. This was because '... many organisations recruited more staff than they could afford to pay for ...' which as a result '... was a major cause of the widespread deficits which emerged across the NHS from 2004-05 onwards' (House of Commons Health Committee 2007a, p.29). This example from England

demonstrates the limited governance systems in place both within organisations and across the healthcare system. There are no particular sanctions if workforce planning fails to deliver as to date an undersupply has been resolved through active overseas recruitment whilst in situations where there is an oversupply, posts are removed or staff are made redundant and the increased competition for the remaining posts enables organisations to have a greater choice over the selection of new employees. In the future the option to recruit Registered Nurses from overseas may not be available due to the predicted global nursing shortage (Buchan and Calman 2004; Simeons, Villeneuve and Hurst 2005; O'Brien-Pallas et al. 2005; International Council of Nurses, Florence Nightingale Foundation and the Burdett Trust for Nursing 2006; Organisation for Economic Co-operation and Development 2008). Despite this prediction there has been no indication that international recruitment would be a challenge if the UK decided to undertake it.

This thesis aims to gain a greater insight into nursing workforce planning and how this has changed with devolution by addressing the following two research questions:

- *What has been the impact of devolution on nursing workforce policy and planning across the four countries of the UK over the period 1997-2009?*
- *How and why have the approaches to nursing workforce policy and planning changed across the four countries of the UK over the period 1997-2009?*

In order to answer these questions the researcher identified the following key issues which emerged from the review of the literature on NHS nurse workforce planning and which will be investigated further in this thesis:

- lack of clarity over responsibilities for nursing workforce planning
- deficits in workforce planning capacity and capability
- central ('top down') versus local ('bottom up') approaches to workforce planning

- the lack of integration between workforce, service and financial planning
- the need for better integration between workforce planning for medical and non medical professions.

These areas were explored in the interviews with key stakeholders from across the four countries of the UK and the feedback is reported in the Nursing Workforce Planning Section of chapter six, the Analysis of Interview Data and Reporting of Findings (section 6.4).

3.4 Nursing Recruitment and Retention

3.4.1 Introduction to Nursing Recruitment and Retention

This thesis aims to gain an insight into how recruitment and retention strategies have changed across the four countries of the UK over the period 1997-2009 and how devolution has impacted upon these strategies. This section of the literature review focuses specifically on nursing recruitment and retention, including why there was a need to increase the size of the nursing workforce in the period up to the interviews in 2008 and what strategies were used across the four countries to achieve and maintain the required growth. The rationale for including a focus on nursing recruitment and retention is that these are key components of the nursing workforce planning process and directly contribute to its success or failure. For example if a workforce plan is developed in isolation of effective recruitment and retention strategies then the plan will not be delivered.

3.4.2 Overview of Nursing Shortages

Prior to the election of the new Labour Government in 1997, patterns of nursing shortages and under funding were emerging across the UK (Smith 2007). In addition to the reported shortages (Unison 1998; Jervis and Plowden 2000), increased demands were being placed on the nursing profession due to changes in the working patterns of junior medical staff (Spurgeon 2000; Chambers 2000). This was principally as a consequence of

the European Working Time Directive (Council Directive 1993), which restricted the working hours for all staff groups and Modernising Medical Careers (Department of Health 2004b), which resulted in changes to medical career structures impacting on the numbers of doctors in training.

Targets for growth in the nursing workforce were developed in three of the four UK countries. In England *the NHS plan* outlined the need for '20,000 extra nurses' by 2004 (Department of Health 2000a, p.11). This was followed by a further target for 35,000 nurses, midwives and health visitors by 2008 (Department of Health 2002a, p.15). In Scotland the *Partnership Agreement* committed to bringing 12,000 nurses and midwives into the NHS by 2007 (Scottish Executive Health Department 2003a, p.25), whilst in Wales a workforce target was set for 6,000 more nurses by 2010 (Welsh Assembly Government 2002). During the period under review, no explicit nurse recruitment targets were identified for Northern Ireland.

In addition to the targets for nursing workforce growth in three of the four UK countries, there was also an increased investment in overall funding for healthcare (Department of Health 2000a; Scottish Executive Health Department 2003b; Welsh Assembly Government 2002, 2003a and 2005a) across the UK, as highlighted in section 3.2.3 of this chapter.

A range of strategies can be employed to deal with shortages in the workforce. A framework for policy responses to address nursing shortages was presented as including five key components:

- increase supply through pre-registration nurse training
- improve retention of the current nursing workforce
- encourage nurses to Return to Practice
- consider the utilisation of nursing skill mix
- recruitment from overseas

(Buchan 2000; Buchan, Parkin and Sochalaski 2003).

Over the period of this study, a range of strategies were employed in the four UK countries to deliver growth in the nursing workforce including:

- increased pre-registration commissions
- widening access to pre-registration programmes
- international nursing recruitment
- nursing skill mix
- flexible working opportunities
- pay and reward
- work environment.

A summary of each of these initiatives is detailed below, along with data on the number of pre-registration commissions in each of the four countries and the number of nurses admitted to the Nursing and Midwifery Council register from the UK and overseas, during the study period.

3.4.3 Recruitment Initiatives

3.4.3.1 Increased Pre-Registration Nursing Commissions

One of the main methods of increasing the nursing workforce is through increased pre-registration training places. Table 3.2 below provides a summary of the numbers of commissions placed for pre-registration nurse training programmes in each of the four countries of the UK over the period under review in this thesis.

The data presented was selected for specific time periods for the following reasons:

- 1998/1999 – representing the start of devolution
- 2004/2005 – devolution had been in place for five to six years
- 2007/2008 – the interviews for this thesis were undertaken in 2008.

Table 3.2 Pre-Registration Nursing Commissions in the Four Countries of the UK at Three Points in Time

Country	1998/1999	2004/2005	2007/2008	% Growth between 1998/1999 and 2004/2005	% Growth between 1998/1999 and 2007/2008
England	16,905	23,377	19,352	38.3%	14.5%
Scotland	2,783*	3,698*	3,437*	32.9%	23.5%
Wales	1,017	1,247**	1,271	22.6%	25%
Northern Ireland	471	826	730***	75.4%	55%
Total	21,176	29,148	24,790	37.6%	17%

*includes midwifery; **equates to figure for 2004; *** equates to figure for 2008

Data sources: Buchan and Seccombe 2002; Buchan and Seccombe 2003; Buchan 2004; Buchan and Seccombe 2006; Buchan and Seccombe 2008; ISD

The figures reported in table 3.2 illustrate substantial growth in the numbers of commissions placed over the period 1998/1999 to 2007/2008, across all four countries. During the first six years following devolution, the total average growth in pre-registration nursing commissions across the UK was 37.6%, ranging from 22.6% in Wales to 75.4% in Northern Ireland. The higher rates of expansion in the pre-registration commissions in Northern Ireland were linked to the shortfall of 2,799 nurses identified in a review of the nursing workforce undertaken in 2002 and the increased pre-registration commissions in response to this (Department of Health, Social Services and Public Safety and KPMG 2002, p.14). Additionally the higher levels of growth in commissions in Northern Ireland may also be attributable to the smaller numbers of nurses trained in Northern Ireland compared with the other three countries.

Between 2004/2005 and 2007/2008 the pre-registration commissions across the UK fell by 15%, reflecting reductions in England, Scotland and Northern Ireland. In Wales the number of pre-registration commissions was broadly stable over the overall period reviewed.

Despite the reductions in commissions across three of the four countries, at the time of the interviews in 2008, the total pre-registration commissions across the UK were 17% higher than the annual number of commissions placed at the introduction of devolution.

The data reported is the number of commissions placed with the Higher Education Institutes responsible for delivering pre-registration nurse education programmes. It was however difficult to obtain accurate and consistent data for the number of places on these programmes which were actually filled, particularly as contradictory information was recorded in different publications for the same time periods, within the same country. The number of commissioned places was higher than the actual number of students subsequently qualifying as Registered Nurses due to attrition from the programmes. In 2006 it was reported that the average attrition rate across pre-registration nursing programmes in the UK was 26.3% (Waters 2008). There was however no agreed methodology for calculating the rates of attrition (Glossop 2001; Unison 2008a) and lower figures were reported from the health departments in England, Wales and Northern Ireland (Waters 2008).

3.4.3.2 Widening access to Pre-Registration Programmes

Strategies were developed to support widening participation in training through accreditation of prior learning and experience (APEL) (Longley, Shaw and Dolan 2007) for example those in Healthcare Support Worker roles. The number of Healthcare Support Workers accessing pre-registration nurse training was relatively small (Department of Health 2006c) but the

attrition rates were reported to be considerably lower where these staff were seconded into nurse training by their employing organisation (Unison 2008a).

3.4.3.3 International Nursing Recruitment

Another method of increasing the nursing supply within short timeframes is international recruitment. During the period 1998-2002, one in four new nursing registrants in the UK was from overseas (Buchan 2002).

Table 3.3 below details the split between those admitted to the Nursing and Midwifery Council register from within and outwith the UK, between 1998/99 and 2007/2008.

Table 3.3 Admissions to the NMC Register

Admissions to NMC Register	1998/1999	2004/2005	2007/2008	% Growth between 1998/1999 and 2004/2005	% Growth between 1998/1999 and 2007/2008
UK	21,901	23,361	23,630	6.7%	7.9%
Overseas	5,033	13,736	4,218	173%	-16%
Total	26,934	37,097	27,848	37.7%	3.3%

Data source: NMC Registrant database

At the time of the introduction of devolution 81.3% of those admitted annually to the register were from the UK. Six years following devolution (2004/05) this figure had dropped to 63% but at the time of the interviews in 2008, 85% annually of those admitted to the register were from the UK.

During the period 1998/99 to 2004/05, the first six years of devolution, there was a large growth in the number of overseas nurses admitted to the Nursing and Midwifery Council register, which equated to a total growth of 173% over this period. This was then followed by a period of decline and by 2007/08 the

number of overseas nurses admitted to the register was lower than the number admitted in 1998/99.

A more detailed analysis of this is included in chapter five – Nursing Workforce Data (section 5.4.2) which provides details of the trends of nurses joining the Nursing and Midwifery Council Register from the UK, the European Union and from outwith the European Union.

It is not possible to differentiate between the admissions to the register in each of the four UK countries due to a lack of country level data and as such it is not possible to assess in detail the relative contribution that international recruitment made to each of the four UK countries. Nursing and Midwifery Council registration data and UK government work permit data only exists in public at a UK level.

The UK's reliance on international recruitment was described as being 'a short-term solution to a long-term problem' (Newman, Maylor and Chansarkar 2002, p.274). The researcher agrees with this assessment as if the workforce planning undertaken to inform the pre-registration nurse education commissions had been more robust then the requirements for increased numbers of Registered Nurses could have been planned for within the UK. Furthermore international recruitment should be managed carefully as it has the potential to exacerbate shortages of personnel in source countries (Zurn et al. 2004).

3.4.3.4 Nursing Skill Mix

In addition to increasing the nursing workforce through the increased training commissions and recruitment of Registered Nurses, alternative solutions include the growth in use of non-registered support staff for example Nursing Auxiliaries, Healthcare Assistants, Healthcare Support Workers or Assistant Practitioners (including Buchan, Ball and O'May 2001; McLeod-Clark 2007; Royal College of Nursing 2007a, 2009; Buchan 2008; Spilsbury et al. 2008).

This workforce is employed in Agenda for Change bands 1-4 and is unregulated but during the period under review, NHSScotland was developing a code of conduct and voluntary registers for this workforce (Scottish Government 2009).

During the 1980s healthcare organisations that provided placements for pre-registration nursing students received funding to recruit Healthcare Assistants or Healthcare Support Workers to supplement their nursing workforce. This additional investment in the non-registered nursing support workforce was as a direct consequence of the implementation of 'Project 2000', the new programme of pre-registration nurse training. 'Project 2000' replaced the apprenticeship model of training with supernumerary status for nursing students during clinical placements. The introduction of supernumerary status effectively reduced the service contribution of the student nurses and as compensation for this; additional Healthcare Assistants and Healthcare Support Workers were introduced to the nursing workforce (Hicks 2000, p.184).

At the time of the interviews undertaken for this thesis in 2008, the number of non-registered nursing support staff employed in the NHS workforce was 186,748¹⁷ which equated to 30% of the total nursing workforce.

There was variability in the education and training received in preparation for Healthcare Assistant and Healthcare Support Worker roles (Knibbs 2005; Knibbs et al. 2006; Spilsbury et al. 2008). These members of staff also received variable levels of supervision from Registered Nurses in the clinical environment (Spilsbury and Meyer 2004; Knibbs et al. 2006).

The Assistant Practitioner¹⁸ is the most senior role in the non-registered nursing support workforce and in the absence of any clear agreement

¹⁷ This figure relates to headcount and was derived from a collation of official government datasets from each of the four UK countries.

¹⁸ In some organisations the term Associate Practitioner is used.

regarding the competencies and underpinning educational preparation, either within individual countries or across the UK, the role has been developed in an ad hoc way. The resultant position is that there is no clear UK-wide strategic vision for the agreed role of the Registered Nurse vis-à-vis the supporting Assistant Practitioner workforce. Furthermore the unregulated Assistant Practitioner role is being seen by employers as a cheaper means of providing care with a growing number of Assistant Practitioner posts being introduced as substitutes for Registered Nurses (Santry 2009; Gainsbury 2009c, 2009d 2009e; NHS Employers 2010).

The absence of regulation of this support workforce presents a risk to patient safety and public protection (House of Commons Health Select Committee 1999a; Royal College of Nursing 2007a) and consequently there is a case for a clear strategic vision across the UK to address consistency in training, supervision and clarity of the different nursing support workforce roles. At the time of the interviews NHSScotland was piloting an employer led registration system for this workforce (NHS Quality Improvement Scotland 2008).

3.4.4 Retention Initiatives

The retention of nurses is influenced by 'adequate economic compensation' and 'healthy work environments' (International Council of Nurses 2006, p.15). A range of the different of strategies aimed at retaining nurses which were identified in the literature are outlined in the sections below.

3.4.4.1 Opportunities for Flexible Working

Flexible working was reported as being important in the retention of nurses (Simeons, Villeneuve and Hurst 2005) and opportunities for flexible working were promoted in each of the four counties through Human Resource Strategies and other policies (Bond et al. 2002; Department of Health 1998, 2000b, 2004a; Department of Health Social Services and Public Safety 2002b; National Assembly for Wales 2000b; Partnership Information Network

2000; Scottish Office 1998b; Scottish Executive Health Department 2000, 2001b and 2003b; Unison 2008b).

Examples of flexible working initiatives include part-time hours; annualised hours and term-time working. Flexible working was reported to improve both motivation and retention of nurses (McNair and Flynn, 2006). In a study undertaken by West, Maben and Rafferty in 2006, nurses reported dissatisfaction with their ability to access flexible working arrangements. In offering access to flexible working healthcare organisations do however need to balance the individual staff member's desire to work particular hours or shift patterns with the need to provide sufficient staffing to cover patient care needs and service demands.

Mixed views have been reported on the impact of part-time working in nursing. A critical review of the international literature on nurse staffing identified that very few studies have specifically looked at the differential impact of full and part-time working (Kane et al. 2007). One study reported that full-time staff described feeling overloaded in their roles (Jolma 1990, cited in Kane et al. 2007) whilst others identified part-time nurses had a better work / life balance (Havlovic, Lau and Pinfield 2002, cited in Kane et al. 2007) and lower personnel costs for employing organisations (Bloom, Alexander and Nuchols 1997, cited in Kane et al. 2007). These studies were undertaken in America, however a UK study reported that part-time work may not provide the flexibility needed by some nursing staff 'forcing many to turn to bank and agency work' as an alternative employment option (Whittock et al. 2002, p.323). Other reports from England have demonstrated that the excessive use of part-time staff and casual employees had an adverse impact on patient care (Audit Commission 2001b; National Audit Office 2006; House of Commons Public Accounts Committee 2007); these studies did not however differentiate between the impact of part-time workers and casual employees.

3.4.4.2 Pay and Reward

Throughout the development and implementation of *Agenda for Change*, the overhaul of pay, terms and conditions for NHS staff, it was explicitly stated that this policy aimed to improve recruitment and retention (Department of Health 1999b and 2004d). Despite this an evaluation of the impact of the *Agenda for Change* reported that the NHS annual staff survey results from 2003 (before implementation of *Agenda for Change*) through to 2006 (post implementation), showed no improvement in the staff 'intention to leave' score (Buchan and Evans 2007, p.18). A review of *Agenda for Change* undertaken by the National Audit Office (2009) did not report any evidence of improved nursing recruitment or retention specifically related to the implementation of this policy. The evaluation of the impact of *Agenda for Change* was complicated though due to the financial challenges some healthcare organisations faced post implementation of *Agenda for Change* (Duffin 2006; Foster 2006b) which made it difficult to distinguish between the impact of *Agenda for Change* and that of the financial deficits in some organisations.

3.4.4.3 Satisfaction with Work Environment

Job satisfaction was shown to have a direct impact on nursing retention (Newman, Maylor and Chansarkar 2002; Wilson 2006; Jasper 2007), whilst Shields and Ward (2001) described this as being the single most important determinant of NHS nurses' intention to quit employment. There are limitations associated with the use of job satisfaction scores as an indicator due to the fact that job satisfaction scores can vary when assessed at different points in time and staff can be more or less inclined to complete these surveys depending on how they are feeling at the time. In addition to this there are other factors such as benefits of current employment and availability of comparable alternative employment, which can have a bearing on whether nurses actually leave employment even when demonstrating low job satisfaction scores.

Feeling valued and listened to at work, along with good working relationships with managers were cited as important factors impacting upon nursing turnover (Barron, West and Reeves 2007). Other studies identified the importance of strong nursing leadership on influencing nursing retention (Shobbrook and Fenton 2002; Force 2005).

Shortages of staff and poor management were also reported to have a significant impact on job satisfaction and retention (Newman, Maylor and Chansarkar 2002), whilst other studies identified a correlation between nurses' inability to provide patients with good care (West, Maben and Rafferty 2006) or barriers to care in the workplace (Reeves, West and Barron 2005) and their intentions to leave both their current post and the nursing profession. A key message from this study was the need to focus on providing the right conditions to enable nurses to deliver high quality care (West, Maben and Rafferty 2006, pp.74, 75).

3.4.5 Summary of Key Points on Nursing Recruitment and Retention

Overall the literature demonstrates that there were a number of initiatives and variables which impacted upon the recruitment and retention of nurses across the UK during the period under examination. The relative merits of these approaches were however unclear. Similarly it was not possible to assess if a particular approach was more or less successful in one country or another. In order to gain a greater insight into this, one of the key lines of enquiry in the interviews for this study was to ask interviewees to identify the three most successful initiatives for nursing recruitment and the three most successful initiatives for retention. This feedback is reported in chapter six (Analysis of Interview Data and Reporting of Findings section 6.5).

3.5 Summary of the Literature Review

One of the key findings from the literature review was that although there have been a few studies into devolution and constitutional change, there has been limited research into the impact of devolution upon healthcare. In

particular there was a lack of research into the impact of devolution on nursing workforce policy and planning.

As devolution has progressed in different ways across the four countries of the UK, healthcare policies have developed to meet the needs of each country but it is not clear from the literature what was the extent to which nursing has influenced this policy development or merely reacted to it and how this varies across the four countries. This is closely linked to the strength of nursing leadership and the mechanisms which exist to influence policy development and decision making in each country.

As nursing is the largest professional group in the NHS, the effectiveness of workforce planning is critical to ensuring that there are sufficient staff with the required skills to deliver high quality patient care through cost effective means. The literature on NHS nursing workforce planning identified repeated reviews, each making the same recommendations to improve planning but on-going deficits remaining to be addressed.

Owing to the nursing shortages in the UK at the beginning of the period under research, different strategies were utilised to recruit new nurses into the profession and to retain existing nurses in the workforce. The workforce targets were met or exceeded but there was an absence of evidence, in the literature reviewed, detailing the relative merits of the different approaches to addressing the shortages either within individual countries or across the four countries.

This literature review highlighted important gaps which were identified as areas for further investigation in the study. These were to gain a greater understanding of:

- the impact of devolution upon the nursing workforce policy and planning

- the changing patterns of power and influence on nursing policy development since devolution
- the key healthcare policies which have influenced nursing most significantly since devolution
- how and why approaches to nursing workforce policy and planning have changed, including the relative effectiveness of initiatives to recruit and retain nurses.

The key issues emerging from the literature review were used to inform the development of the interviews and primary research undertaken for this thesis. Each of these areas will be explored on both a UK wide and individual four country basis following the same sequencing used in the literature review and as informed by the conceptual framework outlined in chapter one.

Having identified the key gaps in the literature on devolution and health that will be examined in the research phase; this thesis now moves on to set out the theoretical background to the research methods utilised in this study.

Chapter Four - The Research Approach

This chapter describes the decision making process in determining which research methods were appropriate to meet the research questions, the rationale for their selection and their application within this thesis. It is presented in three sections, the first of which provides details of the research paradigm; methodological approach; data collection methods and justification. The second section outlines the implementation of the research methodology and data collection methods adopted, whilst the third summarises the process for analysing the data.

4.1 Research Methods

4.1.1 Overview of Research Methods

At the outset of the study a range of research methods were reviewed and assessed and an initial, provisional view was formed that evaluation research was a suitable methodology, as this study was concerned with the impact of devolution on nursing workforce policy and planning in the UK. Evaluation research is defined as being 'the systematic application of social research procedures for assessing the conceptualisation, design, implementation, and utility of social intervention programmes' (Rossi and Freeman 1993, p.5). Evaluation research is particularly suited to policy research and 'primarily concerned with determining the merit, worth or value of an established policy or planned intervention' (Clarke and Dawson 2005, p.3). This focus of this evaluation study was principally commentary on nursing workforce policy and planning.

Crotty (2010) acknowledged that when embarking on a research study the researcher starts with a real life issue requiring investigation. This in turn leads the researcher to appraise different methodologies and assess their applicability to the research questions proposed. Cresswell, Plano Clark and Garrett stressed that 'researchers must display ingenuity in building customised solutions to their methodological dilemmas using their research experiences' (2008, p.81). This may result in the need to develop a blended

approach if there is no single methodology that meets the needs of the researcher.

In the context of the research questions the researcher determined that the methods used would have to meet several broad criteria:

- the flexibility to review, interrogate and triangulate a range of relevant data sources including the analysis of health policies; nursing workforce data and the views of key stakeholders from across the UK on the impact of devolution on nursing workforce policy and planning initiatives as informed by their individual experiences
- the ability to capitalise on the researcher's existing areas of expertise including professional knowledge of nursing workforce planning; extensive experience of working as a nurse in the NHS and personal attributes particularly in relation to communication skills.

Crotty (2010, p.3) identified four key elements of the research process each of which require careful consideration and alignment in the research study.

The four elements were:

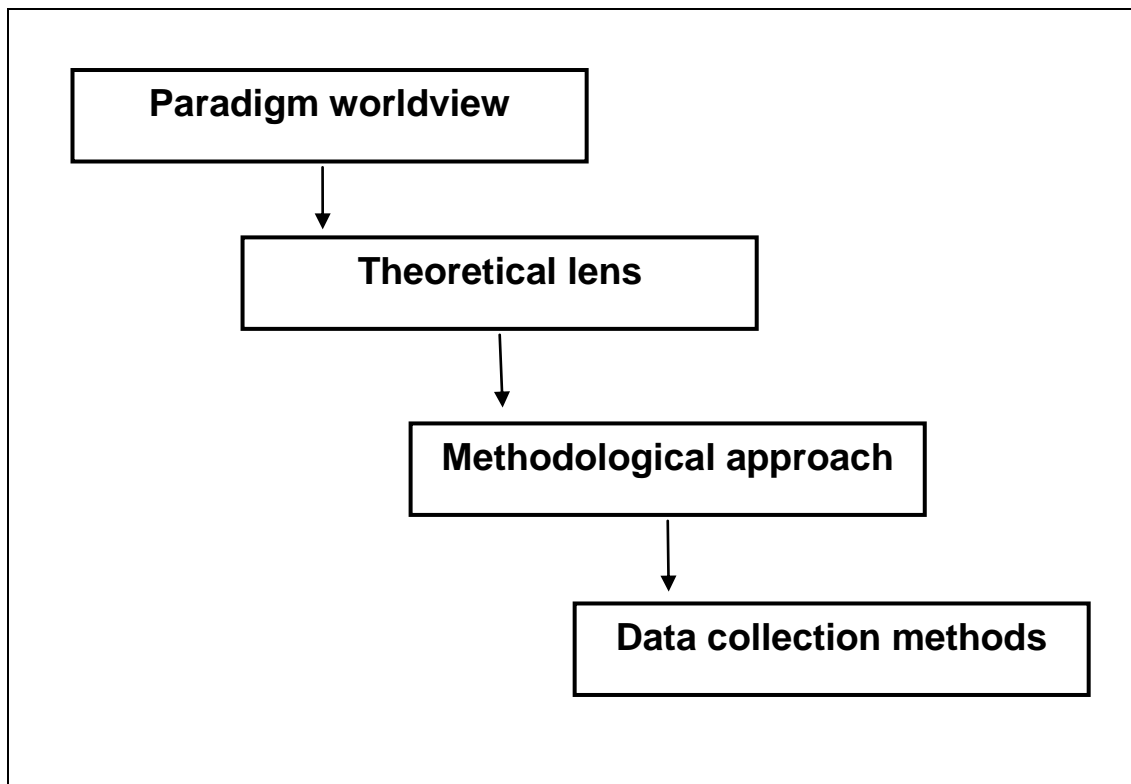
1. 'epistemology – the theory of knowledge embedded in the theoretical perspective and thereby in the methodology
2. theoretical perspective – the philosophical stance informing the methodology and thus providing a context for the process and grounding its logic and criteria
3. methodology – the strategy, plan of action, process or design lying behind the choice and use of methods and linking the choice and use of methods to the desired outcomes
4. methods – the techniques or procedures used to gather and analyse data related to some research question or hypothesis'.

Building on the work of Crotty (2010), Cresswell and Plano Clark (2011, pp.38, 42) adapted these four elements, which they described as levels, as outlined below:

1. Paradigm Worldview – the ‘philosophical assumptions’ encompassing aspects such as the epistemology and ontology. The definition of epistemology being ‘what is the relationship between the researcher and that being researched?’ whilst the definition of ontology is ‘what is the nature of reality?’
2. Theoretical lens or foundations – this provides the ‘stance’ or direction for the research study
3. Methodological approach – ‘a strategy, a plan of action or a research design’ for example quantitative or qualitative methods
4. Methods of data collection – the tools used to gather data for example questionnaires, interviews or focus groups.

Figure 4.1 below is the diagrammatic representation of the four levels of developing a research study, as presented by Creswell and Plano Clark (2011). The researcher used the Creswell and Plano Clark (2011) model to shape the research approach adopted in this thesis. The rationale for this was that this model included the broader ‘paradigm worldview’ as the first level of the study which enabled the researcher to identify the most appropriate epistemology and ontology for use in this thesis. This in turn helped the researcher to work through the three other levels, identifying complementary theoretical and methodological approaches informing the selection of the data collection tools which were subsequently developed for the context of this thesis. Working through this model was a lengthy process but this was beneficial as it enabled the researcher to reflect on the different elements of the research process ensuring each was addressed and that the approach taken was structured, integrated and appropriate to this thesis.

Figure 4.1 The Four Levels of Developing a Research Study



Creswell and Plano Clark (2011, p.39)

The diagrammatic representation presented by Creswell and Plano Clark (2011) depicted a hierarchical and sequential relationship between the four levels. Although this was adapted from the Crotty (2010) model, Crotty himself acknowledged that the relationships between the elements were much less rigid with linkages from left to right and right to left, as well as from top to bottom and bottom to top.

Reflecting on this, the researcher determined that the model developed by Creswell and Plano Clark (2011) did not demonstrate the full extent of interactions between the four levels.

Both of these models focused on the elements or levels of the research process, however on reflection the researcher identified additional factors

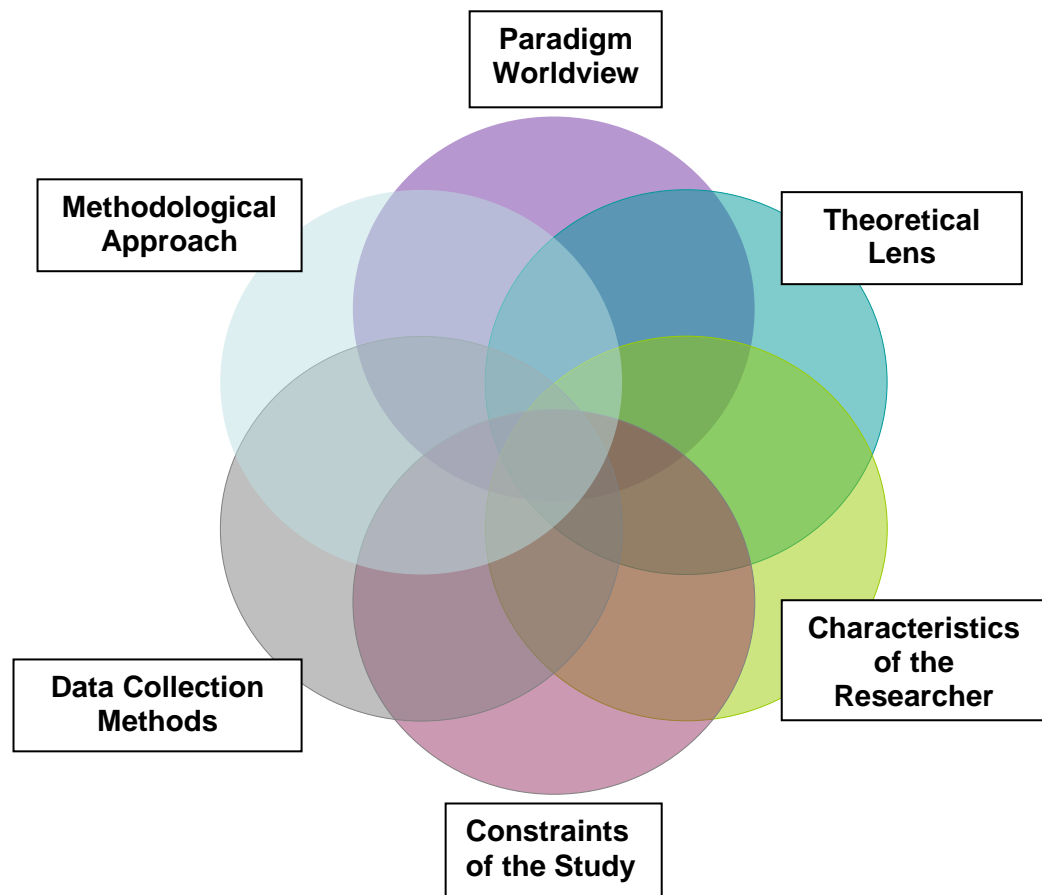
which were not included in either the Crotty or the Cresswell and Plano Clark models. These were:

- characteristics of the researcher (Mason, 1996; Patton 2002; Clarke and Dawson 2005)
- constraints of the study.

Although these were not elements or levels of the research process as such, they were factors which the researcher recognised significantly influenced the selection and practical application of the elements or levels of the research process.

The researcher therefore developed an adapted diagrammatic representation, which demonstrated closer linkages and areas of potential overlap between the original four levels of the Cresswell and Plano Clark model, along with the inclusion of the two new elements.

Figure 4.2 Adapted Representation of the Elements of the Research Process and Associated Factors



Each of these six elements (the original four as defined by Creswell and Plano Clark 2011 and the two additional ones identified by the researcher) will now be considered in the context of this research study. Although each of the elements will be examined individually they are in reality inextricably linked as demonstrated in figure 4.2 above (Adapted Representation of the Elements of the Research Process and Associated Factors).

4.1.2 Paradigm Worldview

The concept of a paradigm originated from Kuhn (1970) and the paradigm worldview outlines the philosophical assumptions underpinning the research study (Cresswell and Plano Clark 2011).

In recent times evaluation research has become more diverse and consequently there have been opportunities to explore the potential for critical realism (Bhaskar 1978; Hammersley 1992) as the underpinning philosophical framework or worldview (McEvoy and Richards 2003). Critical realists believe that 'reality is arranged in levels and that scientific work must go beyond statements of regularity to analysis of the mechanisms, processes, and structures that account for the patterns that are observed' (Denzin and Lincoln 2005, p.13). One of the key features of critical realism is that it draws on 'different levels of analysis and brings them together in order to develop integrated theories that emphasise the effects of generative mechanisms operating at different levels' (McEvoy and Richards 2003, p.416). This aspect of critical realism was particularly beneficial in this current research study as it supported 'linking various levels of explanation' and looking 'beyond surface appearances' (McEvoy and Richards 2003, pp. 416, 418), which enabled the researcher to combine data generated from analysis of healthcare policies and trends in nursing workforce data with the perceptions of individuals employed in different professional roles, in different organisation and from different parts of the UK.

The paradigm worldview influences how the research is undertaken, analysed and reported. It encompasses the epistemology 'i.e. what is the relationship between the researcher and that being researched?' and the ontology the definition of which is 'what is the nature of reality?' (Cresswell and Plano Clark 2011, pp.38, 42). The epistemological and ontological perspectives relevant to this study will now be considered in turn.

4.1.3 Epistemology

Historically evaluation research has been rooted in positivism (McEvoy and Richards 2003). Positivism is based on the premise that 'objective accounts of the real world can be given' (Denzin and Lincoln 2005, p.27). Quantitative research methods have been described as being embedded in positivism, whilst qualitative research has been rooted in constructivism (Bergman 2008, p.11). Constructivism has been defined as building on 'antifoundational arguments while encouraging experimental and multivoiced texts' (Denzin and Lincoln 2005, p.184) or the processes of individuals 'engaging with objects in the world and making sense of them' (Crotty 2010, p.79).

The researcher considered a range of options for the underpinning epistemology for this thesis before concluding that the constructivist epistemology (Guba and Lincoln 1989, 1994) was the most appropriate. The rationale for this choice was that the constructivist viewpoint encapsulates the position that 'meanings are constructed by human beings as they engage with the world they are interpreting' (Crotty 2010, pp.43, 44). Furthermore phenomena can only be evaluated in the context in which they are reviewed (Guba and Lincoln 1989). This approach takes into account the role that individual interviewees have in influencing or interpreting how effective or successful particular policy initiatives have been along with the role of the researcher in understanding and interpreting the data (Patton 2002), both of which were of critical importance in this study. A constructivist viewpoint determines that programmes can only be understood in their natural setting and values equally the different perspectives of individuals responsible for developing the policy, implementing the policy as well as those who are impacted by the policy.

The constructivist stance enables the research design to emerge as the study progresses, which in the context of this particular thesis meant that the key lines of enquiry were influenced by the policy analysis and the literature review (Clarke and Dawson 2005). Furthermore it supports the use of a

semi-structured interview schedule with flexibility to explore new lines of questioning during interviews where this was felt to be relevant to the thesis.

The other epistemologies which were considered in the context of this study were discounted for the following reasons:

- positivism on the basis 'that human behaviours are governed by law-like regularities' (Snape and Spencer 2003, p.23) which the researcher felt was incompatible with the position that individuals have influence on the outcomes of policies or programmes
- postpositivist on the basis of 'singular reality' (Cresswell and Plano Clark 2011, p.42) which essentially requires the researcher to accept or reject the hypothesis and this was felt by the researcher as being too restrictive and not in line with the evaluation of what policies work and why
- participatory epistemology focuses on the issues such as empowerment and marginalisation and frequently involves researchers investigating individual's perspectives of the injustices they are experiencing (Cresswell and Plano Clark 2011), which was not relevant to this study
- pragmatism is focused on understanding how things work in practice and it is more concerned with answering the research question than the methods employed (Cresswell Plano Clark 2011). It was however more difficult to reach a decision on pragmatism vis-à-vis constructivism as there were elements of both of these that resonated with the researcher in relation to the development of this study.

4.1.4 Ontology

The ontology selected for this study was realist ontology. This has been defined as the existence of an external reality which is independent of our understanding or beliefs (Snape and Spencer 2003). Central to realist review is the importance of people in the success of a programme and not merely the programme itself (Wand, White and Patching 2010). Wilson and

McCormack (2006, p.51) acknowledged that both 'the process and context of change' are vital in realistic evaluations. In the context of this study the realist ontological viewpoint necessitated the researcher to look beyond the initial reports of successful policy initiatives to gain a better understanding of the factors that contributed to their success (Kazi 2003). Additionally it enabled an understanding of the reasons why other policy initiatives had been less successful.

The combination of a constructivist epistemology with a realist ontology was considered to be a good match (Hammersley 2002; Crotty 2010), however Kazi (2003) cautioned that within evaluative research attempts to categorise epistemological and ontological perspectives are often problematic due to the potential overlaps between the boundaries of the different perspectives and the influence of the reviewer on how the perspectives have been classified. Furthermore Patton (1990) highlighted the futility of identifying one supreme paradigm, favouring instead the need for methodological flexibility and the ability of the researcher to move between different paradigms.

4.1.5 Theoretical Lens

The theoretical lens has been described as being the 'standpoint taken by the researcher that provides direction' for the research study (Cresswell and Plano Clark 2011, p.47). This has a narrower focus than the paradigm worldview and, in the context of this study; the theoretical lens selected was from the social science discipline in the form of realist review (Bhaskar 1978, 2008; Kazi 2003; Pawson 1997; Pawson 2001; Pawson and Tilley 2004 Pawson et al. 2005). Realist review has been defined as 'a practical adaptation of critical realism that enables researchers to explore beyond the surface of programmes in order to identify and explain what mechanisms are fired in a given context by an intervention to produce certain outcomes' (Wand, White and Patching 2010, p.238).

Realist review provides an 'explanatory rather than judgemental focus' and is specifically designed to work with 'complex programmes' (Pawson et al. 2005, pp.21, 25), which in this study was identifying how approaches to nursing workforce policy and planning had changed over time and what the impact of devolution had been on nursing workforce policy and planning across the UK. Furthermore, realist review provides a means of 'explaining the relationships between the context in which the intervention is applied, the mechanisms by which it works and the outcomes which are produced' (Pawson et al. 2005, p.21). The rationale for choosing realist review for this study was that it would enable the researcher to gain a better insight into and understanding of:

- the perceived significance of individual policies and strategies on nursing workforce planning
- the different drivers in each of the four countries
- the reasons why some policies or initiatives had been more successful than others.

Additionally realist review provided the flexibility to augment the feedback from interviewees with nursing workforce data and policy analysis information.

Central to the realist approach to inquiry is the drive for greater understanding of causality by means of a 'generative model' and Pawson et al. (2005, p.22) described the approach taken in realist review as being one that is based on generating an understanding of the mechanism (M) that links two events, the context (C) in which this occurs and the resultant causal outcome (O). Realist evaluations are therefore about testing out 'CMO' configurations to determine 'what is it about this programme that works for whom in what circumstances?'

A key requirement in realist review is the need for the researcher to take account of the different 'layers of social reality' (Pawson and Tilley, 2004) surrounding interventions which consequently result in the same intervention

being more or less successful depending on the context in which it has been implemented. Pawson et al. (2005, p.23) described these contexts as including:

- 'policy timing
- organisational culture and leadership
- resource allocation
- staffing levels and capabilities
- interpersonal relationships
- competing local priorities and influences'.

This listing identifies some of the potential reasons why well-researched policies may fail to be implemented successfully or why policy initiatives may be successful in one organisation or country but fail in another. Gaining this level of insight into the relative successes or perceived importance of different nursing workforce policy initiatives and interventions was critical to this study. Owing to the complexity of this research study and the wide range of policies which could have influenced nursing workforce planning in the four countries of the UK and the impact of devolution, it was not possible for the researcher to apply this level of rigour to the evaluation of each individual policy.

This study focused specifically on addressing the following two research questions:

- *What has been the impact of devolution on nursing workforce policy and planning across the four countries of the UK (1997-2009)?*
- *How and why approaches to nursing workforce policy and planning changed across the four countries of the UK (1997-2009)?*

These research questions are much broader than the evaluation of one particular programme or a series of related programmes. Therefore, in the context of this study, the researcher applied the generic principles of realist review to address the research questions essentially by considering what

works for who, in what circumstances and why? Additionally where a strategy, policy or intervention has not worked so well, or was perceived to be of lesser importance, consideration has been given to the factors that may have contributed to this. In the reflection section (chapter eight) of this thesis the list of contexts as defined by Pawson et al. (2005), as detailed above, will be reviewed to identify how the findings of this research study map to these contexts.

4.1.6 Methodological Approach

The somewhat outdated argument of the relative merits of quantitative versus qualitative methodologies (Lincoln and Guba 1985; Guba and Lincoln, 1989; Patton 1990; Miles and Huberman 1994) has, over the years, been demonstrated as being redundant with many researchers and research bodies now favouring a mixed methods approach (Greene, Caracelli and Graham 1989; Patton 2002; Sale, Lohfeld and Brazil 2002; Bazeley 2002; Johnson and Onwuegbuzie 2004; Teddlie and Tashakkori 2009; Bergman 2008; Cresswell and Plano Clark 2011).

Traditionally two main methods have been used in social science research:

- **quantitative**

Quantitative research has been described as a 'scientific method as used in natural sciences, with an emphasis on hypothesis testing, casual explanations, generalisation and prediction' (Snape and Spencer 2003, p.14). Quantitative methodology has however been criticised for its inability to 'provide a deeper understanding of social phenomena' (Silvermann 2000, p.8).

- **qualitative**

Qualitative research was defined by Denzin and Lincoln as being 'a situated activity that locates the observer in the world' under investigation (2005, p.1). It uses a range of methodologies that 'celebrate richness, depth, nuance, context, multi-dimensionality and

complexity' (Mason 2002, p.1). Some have argued that qualitative research is more focused on obtaining depth of understanding of an issue as opposed to merely breadth (e.g. Patton 2002; Snape and Spencer 2003).

Mixed methods research encompasses at least one qualitative and one quantitative component in a single research study (Bergman 2008). The use of mixed methods emerged principally during the 1990s (Sale, Lohfeld and Brazil 2002; Denscombe 2008) and has become of increasing popularity, so much so that it has been cited as 'the third methodological movement in the social and behavioural sciences' (Tashakkori and Teddlie 2008, p.101) combining 'quantitative breadth with qualitative depth' (Bryman 2008, p. 88) and with claims of increased validity of findings (Bazeley 2002).

Several reasons have been reported for choosing to undertake a mixed methods research study, including achieving greater understanding of the subject matter and improved results (Denzin and Lincoln 2005) or gaining a better insight into 'complex phenomena' than would be possible through quantitative or qualitative approaches alone (Azorin and Cameron 2010, p.95). Mixed methods research was also reported to have been used in healthcare 'on pragmatic rather than ideological grounds' enabling the researcher to deal with the complexity of the healthcare environment (O'Cathain, Murphy and Nicholl 2007, p.10). The complexity of the healthcare setting has obvious implications for nursing workforce policy and planning and consequently for this study, particularly as it involves the National Health Service within the contexts of the four different countries of the UK.

The definition of mixed methods research can be applied at a paradigm worldview level, or in relation to data collection or data analysis. The mixed methods used in the context of this study were primarily at the level of data collection and analysis as detailed below:

- qualitative in-depth key informant interviews
- interrogation of policy analysis
- quantitative nursing workforce data.

The use of mixed methods research is a key feature of realist evaluation encompassing a range of techniques to ensure the researcher gains the 'depth and detail' of information upon which conclusions can be made with an increased degree of confidence (Clarke and Dawson 2005, p.67) or improved credibility of findings (Patton 1999). Others cited mixed methods more explicitly as the preferred approach for realist evaluation (Pawson and Tilley 2004), enabling the investigation of processes and the impacts of complex interventions (Pawson et al. 2005). However Pawson (1997) also cautioned that realist evaluation is not merely about mixing methods it is much more about the 'logic of investigation' which includes using a realist theory to determine how programmes actually work.

Johnson, Onwuegbuzie and Turner (2007, p124) presented a continuum within mixed methods research with varying degrees of dominance of qualitative and quantitative methods. In this thesis the qualitative component was stronger than the quantitative component which gained the label 'QUAL+quan research'. The dominance of the qualitative methodology within this mixed methods study was therefore compatible with the constructivist epistemology selected as described earlier in this chapter (section 4.1.3).

Tashakkori and Teddlie (2008, p103) detailed seven purposes for undertaking mixed methods research and on reviewing this list the researcher identified the two main reasons which were relevant to this particular study:

1. complementarity – mixed methods enabled the researcher 'to gain complementary views about the same phenomenon or relationship'.
These different views may emerge from interviewees from different

organisations within one country or between interviewees in the four countries

2. completeness – mixed methods were used to gain a complete insight into the phenomenon, based on the assumption that the full picture is more meaningful than the component parts considered in isolation.

The mixed methods approach used in this study has been termed 'triangulation' (Denzin 1989 and Flick 1998 cited in Denzin and Lincoln 2005 p. 722), whereby following analysis, the qualitative data from the key informant interviews and the quantitative nursing workforce data were reviewed, enabling the researcher to develop a greater insight into the subject matter and a more comprehensive response to the research questions, as outlined in figure 4.3 below.

Figure 4.3 Triangulation Design



(Adapted from Creswell, Plano Clark and and Garrett 2008, p.68).

Denzin and Lincoln described triangulation as being 'an attempt to secure an in-depth understanding of the phenomenon in question' (2005, p.5) whilst Patton highlighted that, through a combination of methods, triangulation 'strengthens a study' (2002 p. 247). Although triangulation is the ideal approach, consideration has to be given to the practical issues regarding what can be accommodated within the available resources and timeframes. In this thesis the researcher used the triangulation of quantitative and qualitative methods as a means of achieving 'convergence, corroboration, and correspondence of results' (Greene, Caracelli and Graham 1989 cited in Creswell and Plano Clark 2011, p.62).

As highlighted at the beginning of this chapter, the researcher's initial interest was in evaluation research, the principal purpose of which was to establish if a programme or intervention works (Clarke and Dawson 2005). Evaluation research may be theory based i.e. focused on a 'model, theory or philosophy about how a programme works' (Fitz-Gibbon and Morris 1996, p. 178). However there is more to understanding the success or otherwise of programmes than purely by means of monitoring the inputs and outputs. Realist evaluation is a specific form of evaluation research based on reviewing the actions of individuals and groups, that contribute to the successful implementation of interventions which was described as enabling the evaluator to 'understand how, and under what conditions, a programme's casual potential is released' (Clarke and Dawson 2005, p.32).

Whilst the selection of the paradigm worldview for this research study has been discussed previously, the researcher felt it was important to briefly revisit the implications for worldviews of a mixed methods research study approach. Within mixed methods research there are different options available for the application of worldviews. One approach is the adoption of a paradigm that aligns best with the context of mixed methods research whilst another approach is the use of multiple worldviews whereby the worldview shifts according to the methods being deployed (Creswell and Plano Clark 2011).

The most commonly accepted approach in mixed methods research is pragmatism (Johnson, Onwuegbuzie and Turner 2007) principally as it is associated with collecting data on 'what works', through quantitative and qualitative means, whilst valuing both objective and subjective knowledge (Tashakkori and Teddlie 2003, p.713). Other approaches are the transformative-emancipatory paradigm which acknowledges the different states of neutrality in knowledge, recognising that knowledge is an indicator of power (Mertens 2003 and 2007). More recently critical realism has been

acknowledged and this combines 'a realist ontology. . . with a constructivist epistemology' (Creswell and Plano Clark 2011, p.45), although it was highlighted that this was an unusual choice in mixed methods research outwith Europe (Maxwell and Mittapalli 2010). The reason cited for this was that the term 'critical' has traditionally been associated with the categorisation of 'theoretical lens' as opposed to 'worldview' (Creswell and Plano Clark 2011, p.45).

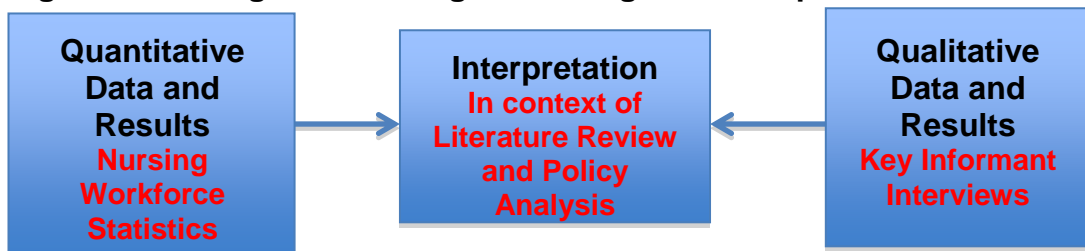
Under the latter scenario there would therefore be three worldviews in this study, one for each of the following methods:

- qualitative in-depth interviews
- interrogation of policy analysis
- quantitative nursing workforce data.

On reflection the researcher chose to utilise the approach whereby the paradigm adopted was the 'best fit' across the mixed methods. Essentially this involved reaffirming the decision taken earlier in the study which was to adhere to the critical realism worldview, encompassing constructivist epistemology and realist ontology. The rationale for this decision was that the primary method of data collection in this study was through the 30 qualitative key informant interviews, the transcripts of which were analysed encompassing the principles of realist review. The other two data collection methods involved secondary data from the analysis of health policies and related documentary evidence, and the review of nursing workforce statistics from existing datasets. These secondary data sources were used to supplement the main data obtained from the qualitative interviews.

The triangulation diagram presented earlier has been enhanced to include the relationships between the key components of data used in this study, as outlined in figure 4.4 below.

Figure 4.4 Triangulation Design including Data Components



(Adapted from Creswell, Plano Clark and Garrett 2008, p68)

4.1.7 Overview of Data Collection Methods

As described earlier it was determined that this study would adopt a mixed methods approach, encompassing three data collection methods. The primary source of data used in this study was from the 30 qualitative key informant interviews with a range of stakeholders in the fields of nursing, healthcare policy and workforce planning across the four countries of the UK. The rationale for the choice of key informant interviews is discussed in the second section of this chapter (section 4.2.3).

There were two secondary sources of data; the first of which was that obtained from the analysis of healthcare policies, strategies and reports on workforce planning, including nursing workforce planning. This data was synthesised and reported in the literature review, used to inform the development of the interview schedules and it aided the contextualisation of feedback from the qualitative interviews. The third source of secondary data was the analysis and review of available nursing workforce data, which was used to provide a background context to the study and evidence to help demonstrate the impact of specific policy initiatives.

4.1.8 Characteristics of the Researcher

Characteristics of the researcher was one of the two additional elements identified by the researcher and included in the Alternative Representation of the Research Process (Figure 4.2). Examples of these characteristics included the researcher's knowledge and experience of research

methodologies, and personal qualities such as the communication skills necessary for some data collection methods for example face to face interviews. The personal attributes, skills, expertise and personality of the researcher could therefore have implications for the methodological approach adopted. This may include the choice of postal self-completion questionnaires or surveys instead of face to face interviews or focus groups, where the researcher has poor communication skills or is daunted by interviewing subjects perhaps related to their professional standing or status. Similarly if the researcher has a greater knowledge base of quantitative or qualitative methods then this may influence their preference for a particular methodological approach.

In the context of this study the researcher tried to ensure that the methods chosen were the most appropriate to developing complete answers to the two research questions. The expertise the researcher had gained in communicating with patients and a wide range of healthcare professionals during her career was beneficial in undertaking the qualitative in-depth key informant interviews. This experience included a sound understanding of confidentiality issues, the ability to communicate effectively with respect and to probe sensitively where information was not forthcoming. These skills helped the researcher to establish a good rapport with the interviewees and enabled her to gain a detailed insight into the issues discussed.

The researcher is aware that her dual role as practitioner working in the NHS in nursing workforce policy and planning¹⁹ whilst also undertaking research on this topic is an area of possible tension, which brings both advantages and disadvantages. The potential advantages include:

- shortly before embarking on this thesis, the researcher was known either in person or by reputation to some of the potential interviewees,

¹⁹ During the period July 2006 – August 2009 the interviewer was employed in roles outwith nursing workforce policy and planning, covering the period when the interviews were undertaken in 2008.

particularly those within Scotland. This may have increased the likelihood of interviewees agreeing to participate in the study

- the researcher's knowledge of workforce policy and planning through direct experience of working within the NHS may have enhanced her credibility with the interviewees as she was conversant with the subject matter during interview discussions
- the researcher's periods of employment within the Scottish Executive Health Department (from July 2003 to March 2004 and from January 2005 to July 2006) equipped her with an increased insight into policy development
- the researcher's employment background assisted her in understanding the available nursing workforce data sources and their limitations.

The potential disadvantages of the dual role as practitioner and a researcher include:

- prospective interviewees may have opted not to participate²⁰ in the study due to the researcher's employment background. There was however no direct evidence to suggest this was a deciding factor for the two individuals who declined to participate or the two who did not respond to the request to be interviewed
- some interviewees may have been more guarded about the responses they provided owing to the fact that the researcher had previously worked within the Scottish Executive Health Department. To mitigate against this, the researcher personally assured interviewees that all interview material would be anonymised and reported in a non attributable format. Although this is in line with standard research governance, the researcher also tried to establish a good rapport with each interviewee encouraging them to be more open in their responses

²⁰ Ten potential interviewees passed the request to a more appropriate colleague within their organisation.

- there was a risk that the researcher would be selective in her interpretation of the interview data based on her knowledge, experience and insight into nursing workforce policy and planning therefore the researcher chose to record the interviews and transcribe the content verbatim. The transcript from each interview was then sent to the relevant interviewee for approval prior to the data being analysed and reported. Additionally a sample of coded transcripts was reviewed by a colleague of the researcher, who had expertise in qualitative research but not in the subject matter.

The researcher has reflected upon her dual role as a practitioner working in the NHS in nursing workforce policy and planning whilst also undertaking research on this topic. The researcher feels this potential tension was managed effectively and on balance, had a positive impact upon the study. The reasons for this assessment are that:

- it provided the researcher with a detailed understanding of the nursing workforce policy and planning context in the UK
- it gave the researcher access to current thinking on issues related to nursing workforce policy and planning during the writing up phases of the thesis
- it was likely to have increased the researcher's access to interviewees
- it was likely to have increased the credibility of the researcher with the interviewees
- it assisted the researcher in undertaking the policy analysis and review of workforce planning data to provide secondary sources of data for the study
- it enhanced the confidence of the researcher when interacting with the interviewees during the study.

4.1.9 Constraints of the study

Constraints of the study was the second element identified by the researcher and included in the Alternative Representation of the Research Process

(Figure 4.2). This included aspects such as financial or human resources available to conduct the research both of which could significantly influence the methodology adopted. Other factors which could impact on the study include the overall timeframes available; the ability to gain access to the desired sample; the willingness of individuals to participate in the research study and limitations in the scope of the study as determined by the sponsoring body or the governance group overseeing the research. In the context of this research study a limiting factor was that the interviews were undertaken in the researcher's own time during annual leave from full-time employment and the associated costs were funded by the researcher. Advance planning and careful scheduling of the interviews were therefore of vital importance in this study.

In addition to the constraints outlined above there were also limitations associated with the realist review method in the context of complex interventions, as acknowledged by Pawson et al. (2005). The theoretical and practical limitations relevant to this study are detailed below along with proposed strategies to minimise their effect:

- a limit on the territory that can be covered - in the context of this study the researcher had to develop succinct research questions and was ruthless in terms of editing down findings
- a limit on the nature and quality of information that can be retrieved - published information that provides one level of detail for example policy documents and reports on the effectiveness of policies or strategies was relatively easy to access. The challenge in this particular study was the volume of relevant policy and strategy documents which had been published in each of the four countries over the 12 year period.

In addition to the documentary evidence there is also softer intelligence which provides insight into interpersonal relationships,

lines of power and influence or other contextual differences which can have a crucial impact on the success and / or perceived importance of policy interventions. This softer intelligence is harder to access but the researcher was able to obtain some insight through the key informant interviews undertaken. Factors which contributed to gaining this increased insight included assuring participants of their anonymity; respecting confidentiality throughout the data analysis process and report writing (Wiles et al. 2006); the design of the semi-structured interview schedule which supported flexibility in relation to the lines of questioning at interview; the communication skills and approach used by the researcher when arranging and conducting the interviews; and the rapport between the researcher and the interviewees. The researcher also obtained 'softer' intelligence by virtue of her experience of working in the NHS, over a 25-year period in both Scotland and England including roles related to nursing policy and workforce planning.

- a limit on what can be delivered by way of recommendations - realist review offers illumination or increased understanding of what may work under what circumstances rather than generalisations across different environments. For example in the context of this study a policy initiative or new role which is successful in one country may not work so well in another country if for example there is a lack of effective leadership or if it cannot be readily translated to the needs of a particular locale.
- the newness of realist review approach and its limited application to date - the lessons learned from the application of realist review in this thesis will contribute to the growing body of knowledge on realist review (Pawson et al. 2005). Furthermore the application of realist review to determine the impact of devolution on nursing workforce policy and planning in the UK is new territory for this methodology.

The researcher was aware that the scope of this study was ambitious principally as it covered the four countries of the UK, across the twelve-year period from 1997-2009. Acknowledging this as a challenge, the researcher intended to use the principles of realist review to identify broad principles or descriptors of what worked well or was perceived as important in each of the four countries related to nursing workforce policy and planning and equally what had not worked so well or was perceived as unimportant and the reasons for this.

4.1.10 Summary of Key Points on Research Methods

This section of the Research Approach Chapter detailed the research paradigm, methodological approach and choice of data collection methods used in this study. In summary the researcher identified critical realism as the paradigm worldview, with constructivist epistemology and realist ontology. This in turn informed the selection of realist review as the theoretical lens underpinning the research study.

The methodological approach adopted was mixed methods research using three methods of data collection:

- qualitative in-depth key informant interviews (primary source)
- interrogation of healthcare policies (secondary source)
- quantitative nursing workforce data (secondary source).

The researcher also considered the impact of two additional elements, which were the characteristics of the researcher and the resource constraints of the study, and how these influenced the approach adopted in this thesis.

4.2 Implementation of Research Methodology and Data Collection Methods

4.2.1 Overview of Research Methodology and Data Collection

This section of the Research Approach chapter will focus on the data collection methods and other factors related to the implementation of the research methodology.

4.2.2 Initial Planning

During the scoping phase at the outset of the study, when the researcher was formulating the research questions, she met with a number of experts in the fields of nursing policy and nursing workforce planning to discuss the broad subject area and to seek views on the suitability of this for a PhD thesis. The experts included Directors of Nursing, policy makers from Government departments, educationalists and researchers in the field of nursing workforce and representatives from 'think tanks'. This dialogue took place on an individual basis with a small number of experts from both Scotland and England. The experts were selected principally from contacts the researcher had developed during the course of her role as Programme Manager, Nursing Workload and Workforce Planning at the Scottish Executive Health Department. Rossi and Freeman (1993, p.454) cited the importance of researchers having a sound understanding of the 'social ecology of the arena in which they work' and this was consistent with the researcher's background knowledge of the subject matter.

Discussions with these experts enabled the researcher to generate ideas that helped to inform the scope of the study and shape its design. This was an iterative process which assisted the researcher in:

- formulating and developing the research questions
- identifying potential stakeholders
- deciding to conduct face to face interviews
- developing the semi-structured interview schedule.

This approach was consistent with the principles of realist review which included the critical importance of discussions with experts in helping to frame the problem under investigation. Pawson et al. (2005) recommended that this dialogue takes place before delving into the literature, which was in line with the approach taken by the researcher in this study.

During 2005, at the same time as the meetings between the researcher and the experts were being held, the researcher also began to undertake a preliminary review of the health policies in each of the four countries of the UK. This enabled the researcher to gain an overview of the policy priorities in each country and the associated implications for the nursing workforce. This commenced with the main health policies since the Labour government came to power in 1997 and continued to be updated during the course of the study until 2009. The policies reviewed are detailed in chapter two and Appendices IV-VII. The policy analysis was used to inform the development of the semi-structured interview schedule.

4.2.3 Ethics Approval

Once the researcher had identified the research questions, the indicative sample of participants and had developed an outline of the methodological approach, contact was made with the Multi-Centre Research Ethics Committee (MREC) for Scotland to seek advice regarding ethics approval. The response received clearly stated that the decision of the Chairman of MREC for Scotland (Committee A) was that the proposed research study 'definitely does not need review'. In addition to this and in line with Queen Margaret University's regulations on ethics, an application was made to the Research Ethics Committee at Queen Margaret University. Questions were however raised by the University Research Committee Chair in relation to the proposal to undertake research involving NHS staff despite the advice received from MREC, Scotland. The researcher opted at this stage to exclude the Directors of Nursing and frontline nursing staff from the study as it was these staff groups that were causing most concern to the University

Research Ethics Committee. On reflection the researcher was also being too ambitious about the manageability of a larger sample size in this study.

Following submission of a letter from MREC, Scotland dated 7th March 2006 (Appendix VIII) to the Queen Margaret University Research Ethics Committee, it was agreed by the Queen Margaret University Ethics Committee in April 2006 that ethics approval was not required for this research study.

Achieving ethical clearance was more challenging than the researcher had expected, principally because the two ethics committees held different viewpoints on the approach being taken within the study. This required the researcher to review and refine the scope of the study resulting in a sample comprising principally of policy leads, senior nursing leaders and nursing workforce planning experts but excluding staff employed directly within NHS organisations.

4.2.3 Rationale for Choice of Data Collection Method

In this study the researcher decided to use face to face semi-structured key informant interviews to collect qualitative data to address the research questions. The other data collection methods which were considered and discounted were postal or online questionnaires and focus groups. The rationale for this decision is outlined below.

4.2.3.1 Interview

The interview is widely used as a method of data collection in evaluation research and has been described as a 'conversation with a purpose' (Dexter 1970, cited in Clarke and Dawson 2005, p.72). Qualitative interviews provide the means of gaining an in-depth understanding of and insight into interviewees' 'situated or contextual accounts and experiences' (Mason 2002, p.65). Interviews can be structured using a pre-determined set of questions or semi-structured incorporating broad topics to guide the

discussions in a more flexible way. In the realist interview process both the interviewer and the participant have roles to play in developing and refining the emergent theory through a two way exchange of information (Pawson 1996; Clarke and Dawson 2005).

The interview provides the opportunity for the researcher to engage with each interviewee on an individual basis and may be conducted by telephone or through face to face contact. The telephone interview is arguably a more effective means of time management for the researcher than a face to face interview, principally where interviewees are geographically disparate or in situations where there are time or resource constraints. The interaction by telephone may be more challenging for both parties particularly where the researcher and interviewee have not previously met, whereas the interaction at a face to face interview enables the researcher and the interviewee to foster an environment which is conducive to obtaining the required information in a more relaxed manner. Furthermore during a telephone interview there is no ability for the interviewer to see the body language of an interviewee or identify non verbal cues. The skills of the researcher in facilitating the interaction, developing a rapport with the interviewee and in outlining the boundaries around confidentiality, process and timekeeping are critical to the success of qualitative interviews.

The interview is a more flexible and less rigid tool than a self-completion questionnaire. During an interview the researcher has the opportunity to gain access to a richer data set as she can include additional lines of questioning in situations where the interviewee raises interesting points which may trigger new lines of inquiry. It is however a key skill of the interviewer to keep the interviewee 'on track' by ensuring that the interviewee does not stray too much into topics which are of little relevance to the study. The semi-structured interview was chosen for this study as it provides the interviewer with the opportunity to ask interviewees questions in an order that fits with the natural flow of discussions rather than rigidly following a predetermined

order of questioning. The interviewer therefore needs to be fully conversant with the issues addressed in the interview schedule customising the interview discussions for each interviewee and ensuring that key questions are not overlooked.

Mason (2002, p.65) recommended using qualitative interviewing where there is a desire for 'depth, nuance, complexity and roundedness in data' related to an individual's experience and perspective. Qualitative interviews predominantly use open ended questions (Silverman 2000) and the researcher was aware that her professional nursing background may have influenced the choice of this approach as it is a commonly used technique in communications with patients and one which the researcher has extensive experience of using. Additionally the listening skills which the researcher developed through her clinical nursing practice were considered to be of critical importance when conducting the key-informant interviews (Guba and Lincoln 1981).

A potential limitation of the interview approach is the possibility of 'recall error' (Patton 2002, p.306), however as there were 30 interviewees in this study the overall effect of this was minimised. There is also the possibility that interviewees will provide responses that they think the researcher wants to hear as opposed to being open and honest. The researcher took action to mitigate against this principally by assuring interviewee anonymity and confidentiality whilst also developing good relationships with the interviewees prior to and during the interviews.

Another drawback of interviews is that they can be challenging to arrange and carry out, particularly where interviewees already have busy schedules. It was therefore essential for the researcher to plan the interview dates well in advance.

4.2.3.2 Questionnaire

Questionnaires may be issued by post or electronically and are generally less time and resource intensive to administer compared with individual interviews, whilst offering the option of greater anonymity (Polit and Hungler 1991). Limitations of the questionnaire approach include, if the questionnaire is completed by hand it may be difficult to understand or the responses may be restricted by the available space; there is a risk that the respondent could misunderstand the questions being asked resulting in sections being omitted or the provision of partial or inappropriate responses; there is also no certainty that the respondent was the one who completed the questionnaire; and the respondent may be more guarded about committing information to paper than he / she would be about having an open and frank face to face discussion.

More information can be gleaned through the use of open ended questions in questionnaires, however Clarke and Dawson (2005) recommended limiting their use particularly in situations where these require self-completion owing to the potential for broad responses which are difficult to categorise and may be misinterpreted by the researcher. In qualitative research, questionnaires are most appropriate where there is a requirement for a superficial analysis of a broad range of views (Mason 2002).

One of the main disadvantages with the questionnaire approach is the potential for a high rate of non response from the respondents (Teddlie and Tashakkori 2009).

The option of an approach based on the use of a questionnaire completed by the respondent was discounted in this study principally because the researcher was concerned that the complexity and length of any questionnaire required would be off-putting to the respondents and therefore be likely to receive a low response rate. Additionally the researcher favoured the alternate approach of gaining a greater understanding of the responses

raised through a face to face interaction and the opportunity to seek further clarification where necessary.

4.2.3.3 Focus Group

Focus groups are essentially group interviews which enable the researcher to gain an insight into the 'attitudes and opinions of groups' (Clarke and Dawson 2005, p.77) but this was not a key objective of this particular study.

The researcher did not select the focus group approach for the following reasons:

- it was not felt to be the most effective means of eliciting the individual viewpoints of interviewees
- in this study the focus was on gaining insight from individuals in senior positions and not on teams working together
- the individual interviewees in this study were not a group, as they were located in many different places across the UK and employed by several different organisations
- the researcher was not confident in her own ability to manage the potential group dynamics of the sample selected for this study. This related particularly to the challenges of ensuring that all interviewees had the opportunity to voice their views and the researcher's ability to re-focus the discussions if they strayed away from the subject matter
- it would be difficult for the researcher to facilitate the discussions in addition to trying to take notes during the session. The use of digital recording equipment may have resolved this issue however it would have been tricky for the researcher to keep track of who was providing feedback at any given time during the session
- one of the main disadvantages with the focus group approach is the pressure that the group exerts upon interviewees 'to conform to a socially acceptable viewpoint' rather than to raise divergent views (Finch and Lewis 2003, p.188). It is possible that some participants may feel guarded during focus group activities and hold back from

expressing their true beliefs as these may not be compatible with the professional role they hold or they may feel intimidated by other group members

- the logistics of co-ordinating multiple diaries to secure a date and time when a number of participants would be available to participate.

4.2.4 The Sample

4.2.4.1 Sampling Strategy

A key feature of qualitative interviews is the use of small samples of people 'nested in their context and studied in-depth' (Miles and Huberman 1994, p. 27). In realist review studies stakeholders are generally selected by virtue of their ability to provide data on how particular programmes or interventions work. However it should not be assumed that they will have all the answers or that they will be in agreement with each other regarding what works for whom and in what circumstances, particularly as interviewees may have been involved in or had exposure to different stages of an intervention (Pawson and Tilley 2004). In this study there is also the dimension that interviewees may have variable experiences or perspectives depending on the country or organisation where they were employed.

The researcher decided to use a purposive sample (Morse and Field 1995) which enabled the selection of individuals who could illustrate or provide insight into the features or processes under review (Silverman 2000). Sampling strategically across a range of contexts increases the likelihood of being able to 'understand how things work in specific contexts, but also how things work differently or similarly in other relevant contexts' (Mason 2002, p.125).

In this study there were several factors that determined the selection of purposive sampling including:

- the need to include a range of specialist expertise in the study

- the small number of individuals in each of the countries of the UK who have a detailed understanding of the subject matter
- the desire to have relatively consistent representation, in terms of job role and employing organisation, across the four countries of the UK.

One of the limitations of purposive sampling is that there is potential for bias if there is insufficient representation of a range of viewpoints in the sample (Mason 1996). A sampling strategy was developed by the researcher, to minimise such bias and to ensure consistency of representation across each of the four countries. The aim was to select a group of interviewees who are strategically placed to provide detailed insight into the research questions (Gerson and Horowitz 2002). Purposive samples are generally small and estimated to be in the region of 30 stakeholders (Teddlie and Tashakkori 2009, p.174).

4.2.4.2 Selection of Sample

Interviewees were selected by virtue of their role, employing organisation, experience of the health policy process and their involvement in nursing workforce planning. In order to protect the anonymity of the interviewees, the researcher has chosen only to list the broad types of organisations where interviewees were employed which included government departments, professional bodies, trade unions, audit organisations, 'think tanks' and academia. At the outset of the study the researcher considered including representatives of Directors of Nursing and frontline staff from NHS organisations in the sample as a means of assessing the impact of nursing workforce policy and planning at both national four country and local NHS organisational levels. The inclusion of Directors of Nursing and frontline nursing staff was later discounted as it was felt to be too ambitious within the time and resources available and because the focus of this research was on national policy.

As a means of raising awareness of the research study and gaining commitment from senior policy leads across the UK, a 'flyer' (Appendix IX) was prepared and circulated to the Chief Nursing Officers and Workforce Leads in the four countries of the UK during August 2007. This was sent by the Chief Nursing Officer in Scotland, as the researcher had previously worked as a member of his team. Shortly after this, during September and October 2007, individual personalised letters (Appendix X) were posted to 35 key stakeholders across the four countries. The pack included an information sheet for potential interviewees (Appendix XI), a consent form (Appendix XII) and a stamped addressed envelope for return of the completed consent form. In addition to the hard copy of the information posted, an electronic copy was emailed to each potential interviewee. Contact details for each of the interviewees were identified mainly through internet searches or from the researcher's work colleagues.

Of the 35 letters issued 21 of those who were invited to participate agreed to be interviewed; ten passed the request to another person within their organisation; two people declined to participate and two individuals did not respond to the researcher's correspondence despite repeated attempts to make contact. All ten of the individuals who were passed the original request from their manager or colleague agreed to participate, although one of the ten had already been approached directly by the researcher and had agreed to participate. This meant that a total of 30 people were in the sample for interview.

One of the two who declined to participate reported that this was due to other work priorities in the organisation but expressed an interest in receiving the findings of the research when it was complete. The other who declined passed the request to an alternative department for participation but the researcher had already invited representatives from this department to participate in the study and they had agreed to be involved.

On the day of interview one of those who had agreed to participate was off sick and as the researcher had travelled to Scotland for the interview, another colleague offered to cover and the researcher accepted. Prior to the interview, the researcher outlined the background to the study, assured the new interviewee of anonymity when reporting the findings of the research. Following this discussion the new interviewee agreed to participate in the research and signed a consent form. In summary the invitation letter was issued to a selected sample of 35 key informants and from this a total of 30²¹ people were interviewed.

4.2.4.3 Characteristics of the Sample

The representation of the 30 interviewees across the four countries was as follows:

- England – eleven (37%)
- Scotland – seven (23%)
- Wales – six (20%)
- Northern Ireland – six (20%)

As there was only one interviewee with a truly UK-wide role, in terms of ensuring confidentiality and anonymity, the researcher made the decision to include this interviewee's feedback with that from the interviewees from England. This was justified by virtue of the fact that the UK interviewee had a dual role and worked primarily within England.

Overall there were more interviewees from England than from the other three countries but this reflects the larger size of England.

20 of the final sample of interviewees were female whilst the other 10 were male, although gender did not form part of the selection criteria. From the researcher's knowledge of the interviewees she identified that 12 were Registered Nurses, 12 had no nursing background but it was not clear if the

²¹ The 30 interviewees include the substitute for the interviewee who was unavailable due to sickness.

remaining six had a nursing qualification or not. Some of the posts held by interviewees do require a nursing qualification for example Chief Nursing Officers. However possessing a nursing qualification was not part of the selection criteria for this study as the interviewees were selected primarily for their knowledge and expertise in relation to nursing or workforce policy and nursing workforce planning. Five interviewees were male nurses equating to 17% of the total sample and 28% of the possible maximum number of Registered Nurses in the sample. This range is considerably higher than the 10.7% of the total population of Registered Nurses and Midwives in 2008 who were male (NMC registration statistics) but this is not surprising as there is a larger percentage of men employed in more senior nursing roles (Vere-Jones 2008).

4.2.5 Development of Interview Schedule

The researcher developed a semi structured interview schedule for a number of reasons including:

- ensuring consistency of approach across all 30 interviews
- guiding the researcher during the interviews
- focusing the researcher on the key issues to be explored with the aim of maximising the effective use of limited time
- assisting the interviewer to keep the interviews '*on track*' and to time
- acting as an aid to keep the interviews focused on what was potentially a diverse topic area
- facilitating the researcher in preparing unbiased questions for use at interview
- providing a template for recording information during the interviews.

Key themes identified from the policy analysis, literature review and discussions with experts were used to inform the development of the semi-structured interview schedule. The broad topic areas incorporated were:

- devolution

- health policies (particularly the main health policies to have influenced the nursing workforce)
- nursing workforce planning
- nursing recruitment and retention
- new nursing roles
- country specific issues
- organisation specific issues

Under each of these broad categories the researcher developed a range of questions which were available for use; however within the semi-structured interview framework there was scope for the researcher to adapt the lines of questioning. This allowed the researcher to apply a baseline level of consistency to the interview process, whilst having the flexibility to pursue additional lines of enquiry where this was of value in generating a greater understanding of a particular topic or in surfacing new issues which were omitted from the original lines of questioning.

The researcher also tailored the interview schedule to the context of the country where the interview was taking place. This enabled the researcher to demonstrate a baseline level of understanding of the specific policies and relevant structures within each of the four countries. Similarly, the interview schedule was customised to the role and work of particular organisations to ensure that an accurate reflection was gained of each organisation represented in the study.

4.2.6 Planning the Interviews

4.2.6.1 Pilot Interview

Gerson and Horowitz (2002) recommended that successful interviews are dependent on the development and piloting of the interview schedule. Polit and Hungler (1991, p.62) also advocated piloting as a 'trial run' involving subjects who possess the same characteristics as those in the main sample. A pilot interview was therefore carried out on 18th January 2008 with a former

colleague of the researcher, who had expertise in nursing workforce policy and planning in Scotland. Although the interview format did not replicate exactly that used in the study, in that it was conducted by telephone and it was not recorded, it was beneficial to the researcher in terms of testing the lines of questioning in the interview schedule, gaining feedback on the process and on the range of topics covered. The fact that the researcher had previously worked with the interviewee enabled an open and frank discussion following the pilot interview. Overall the feedback from the pilot process was positive and resulted in some minor amendments to the wording of a few questions to improve clarity.

4.2.6.2 Consent to Participate in Study

Signed consent forms were received from each interviewee prior to arranging the date and time of each individual interview. A record of the completed consent forms has been retained by the researcher. The researcher agreed to conduct the interviews in a location of choice for the interviewee and this was clearly documented in the information sheet circulated prior to the interviews.

4.2.6.3 Scheduling of the Interviews

A careful planning process had to be developed to co-ordinate the interviews across the four countries as these were carried out when the researcher was on annual leave from full-time employment.

Generally the interviews were conducted in each interviewee's place of work, which involved the researcher travelling to nine different towns or cities across the UK including: London, Edinburgh, Glasgow, Cardiff, Swansea and Belfast. The other locations are not detailed to help maintain interviewee anonymity. Multiple visits were required in some of the locations, particularly London. The fact that the researcher was willing to travel to a location of the interviewee's choice may have positively influenced the high participation rates.

The first interview was held on 21st January 2008 and the final interview was held on 22nd May 2008. Each interview lasted approximately one hour although the duration ranged from 43 minutes to 108 minutes. A detailed schedule of the interviews is contained in Appendix XIII.

The interviews were planned well in advance thus enabling more than one interview to be held on the same day or over successive days. This was beneficial for a number of reasons namely:

- it made best use of the researcher's time
- it was more cost effective as travelling expenses and hotel costs were minimised
- the researcher was firmly focused on the policy context within that particular country
- there were opportunities for the researcher to seek immediate clarification if following an interview the researcher was unclear about a particular comment or issue.

The first cohort of interviews was undertaken in Scotland and there were several reasons for this:

- all the interviewees in Scotland were known to the researcher through her previous role as Programme Manager for Nursing Workload and Workforce Planning at the Scottish Executive Health Department
- the researcher had a sound understanding of the Scottish health policy context as she had worked in Scotland for the majority of her career
- the researcher felt more comfortable undertaking the first set of interviews within a familiar setting.

The interviews were generally conducted in the following sequence:

- Scotland
- England

- Wales
- Northern Ireland.

The researcher had previously had contact, on a professional basis, with some of the interviewees from England. This sequencing enabled the researcher to build her confidence in undertaking the interviews with participants with whom she had met previously before conducting interviews with individuals she had not previously met.

4.2.6.4 Conducting the Interviews

In preparation for the interviews, the researcher rehearsed the key lines of questioning that she planned to ask during the sessions. For example an interview with a representative from a Professional Organisation or Trade Union would include questions tailored to the strategies or initiatives of that interviewee's employing organisation. Additionally the researcher referred to her review of the health and nursing workforce policies from each relevant country to ensure that she was conversant with these prior to the interviews.

At the start of the interview the researcher sought permission from each interviewee for the interview to be recorded and all interviewees consented to this. The recording was made with the aid of an Olympus Digital Voice Recorder. The recorded interviews were then saved as Windows Media Audio files prior to transcription. The researcher also took notes during the interview as back up and these served as a summary of the key points discussed. Note taking was however kept to a minimum as the researcher wanted to ensure that writing during the discussions did not adversely affect the conversation flow.

During the interviews the pre-prepared schedule of questions was used as the framework to guide discussions. Following this schedule ensured a consistent approach to the topics covered during each interview, whilst

enabling the interviewer to be flexible to explore new lines of inquiry if these arose in the course of discussions.

The researcher began each interview session with a personal introduction and provided background information on the research study. Assurance was given that the information obtained during the interview would be treated with the strictest confidence and would be reported in an anonymised format in the final thesis. Although often used interchangeably the terms anonymity and confidentiality are distinct for example in addition to the anonymisation of data there is also a need to ensure the confidentiality of individuals participating in the research study by virtue of how the data is recorded, stored and reported (Wiles et al. 2006). This reassurance was of particular importance owing to the small numbers involved in the study and the specialist nature of the posts held by some of the interviewees, which could have resulted in individuals being identifiable in the thesis if due care and attention was not paid to ensuring confidentiality.

There were instances during the interview discussions where consistent responses were provided to a particular line of questioning and it became clear to the researcher that no new information was forthcoming. This is commonly referred to as 'saturation' (Morse 1995). Where this was identified during the interviews, the researcher decided to stop following that particular line of questioning, choosing instead to pursue other topics. If the 'saturation' was identified in one particular country the researcher would continue to ask the question in the other three countries until 'saturation' was detected amongst the responses from each country. One of the consequences of this approach was that not every interviewee was asked the same questions and therefore when reporting the findings the fact that a particular phenomenon was not recorded in all the interviews may be due to the fact that as 'saturation' became evident that particular question was no longer asked.

The flexible approach adopted was consistent with semi-structured interviewing and provided capacity for the researcher to explore new lines of questioning with interviewees as opposed to focusing on a narrower range of topics. This created the opportunity to gain new knowledge and insight whilst enabling the interviewees to have a stronger role in shaping the lines of questioning which was in accordance with the principles of realist review.

At the end of the interview session the researcher asked each individual interviewee if there were any other matters they wished to raise which had not been addressed during the interview. A few interviewees raised additional issues including forthcoming policy work or subject matter for future reviews, potential links to the social care workforce and suggestions for additional contacts, some of whom were already part of the study sample. The researcher thanked each interviewee for their time and for sharing their views on the issues discussed.

4.2.7 Transcription and Approval of Interview Data

It had been the researcher's original intention to use the summary notes taken during the interviews as the main source of data for analysis, referring to the taped material for clarification where necessary. Following the interviews, the researcher reviewed the notes she had taken and compared these with the recordings of the interviews and was struck by how selective her notes were. Ritchie and Spencer cautioned that even where the same person is involved in collecting and analysing the data 'it is likely that recollections will be selective and partial' (2002, p.312). As there was a need to ensure that a robust process was followed, it was therefore decided to transcribe each of the interviews verbatim, prior to undertaking any analysis of the data. This purist approach was employed to minimise the potential bias of the researcher.

The process of transcribing the interviews was a lengthy one and the researcher paid an administrative assistant to support her with the

transcription. The importance of participant confidentiality was paramount and the researcher prepared a confidentiality agreement which the Administrative Assistant agreed to comply with and signed. Each voice recording and completed transcript was identifiable only by the unique anonymous code assigned to it.

On completion of a typed transcript the researcher checked every record against the relevant interview recording, making amendments where necessary. This was again a lengthy process but one which enabled the researcher to become fully immersed in the interview data. The end result of this process was a verbatim transcript for all 30 of the interviews undertaken.

The researcher then emailed the completed transcript to each interviewee for final approval. The majority (18) of the transcripts were returned with no amendments and eight interviewees highlighted minor amendments which included typographical errors and adjustments to phraseology. Two interviewees highlighted the importance of confidentiality when reporting the information and reassurance of this was provided again. Two interviewees did not provide feedback on the transcripts despite reminder emails. The final email sent from the researcher alerted these two interviewees to the fact that if no reply was received by the final deadline indicated then the researcher would assume that the interviewee was in agreement with the content. The researcher was satisfied that this approach was reasonable as both of these interviewees had provided written consent agreeing to be involved in the study at the outset and had not voiced any concerns during the interview process or following it.

4.2.8 Confidentiality and Anonymity

Each interviewee was assigned a unique identification code comprising of two or three letters to represent the country he / she was employed within, as detailed below:

- ENG – England
- SC – Scotland
- WAL – Wales
- NI – Northern Ireland

A consecutive numbering system was then applied as a suffix to these letters for example ENG01, ENG02 and ENG03. The numbers used followed the sequencing of the interviews for example the first interview undertaken in Scotland was coded SC01, whilst the last interview undertaken in Northern Ireland was coded NI06. The researcher decided to report the findings of this thesis with the inclusion of this coding to highlight the areas of commonality and difference in feedback between interviewees in each of the four countries.

The taped recordings of the interviews, the researcher's hand written notes and the transcripts of the interviews were each assigned a unique interviewee identification code which was only known to the researcher. All the data was stored confidentially in accordance with information and data governance requirements (Department of Health 2006d; Department of Health 2007a). All interview recordings and verbatim transcripts were saved electronically in an anonymised format, under password protection and the computer was secured within a locked environment.

The researcher ensured that the confidentiality and anonymity of the participants was maintained from the outset of the research. The strict adherence to confidentiality was outlined in the correspondence issued inviting potential interviewees to join the study. The researcher was keen to promote open and frank discussion amongst the interviewees during the interviews and critical to this approach was the assurance of interviewee anonymity. Overall the relatively small sample of 30 interviewees, with expert knowledge of the subject matter, could result in individuals being identified if due care and attention was not taken.

During the analysis phases of the study all data was identifiable only by the unique codes assigned. Furthermore any reference to interviewees in the report was by the means of the unique codes and where there was a particular risk of exposing the identity of an interviewee then this was reported as one interviewee from England (ENG) or the relevant country, instead of using the full unique identifier. When providing background details of the sample, the researcher provided a high level summary of the types of organisations the interviewees were employed within, as a means of protecting the anonymity of the interviewee and respecting confidentiality.

4.2.9 Reflections on the Data Collection Method

On completion of the data collection phase of this thesis, the researcher reflected on the methods used to identify shortcomings that may have influenced the findings. The researcher recognised that several factors could have affected the responses to the questions asked during the interviews including:

- the interviewee's current or previous role(s)
- the length of time the interviewee has worked in strategic leadership or policy roles
- the priorities and strategic vision of the interviewee's employing organisation(s)
- personal involvement of interviewees in influencing or developing particular policies, strategies or campaigns
- individual interviewee's experiences of implementing or evaluating particular policies
- selected recall of events over a ten year period.

The selection of a purposive sample of 30 key informants from across the four countries of the UK served to minimise the impact of these factors. Additionally the use of semi-structured interviews enabled the researcher to probe issues or explore topics in more depth where necessary.

4.2.10 Summary of Key Points Research Methodology and Data Collection Methods

This section of the Research Approach chapter has described the practical implementation of the research methodology; the rationale for selecting semi-structured key informant interviews as the method of data collection; the planning work undertaken to prepare for the interviews; an overview of how the interviews were conducted and the process for transcribing the interview data. It also provided details of the sample used in the study and the communications with this group. Some of the potential limitations of the data collection methods used by the researcher were highlighted along with the strategies employed to overcome these.

4.3 Process for Analysing Data

4.3.1 Overview of Data Analysis

This section provides an outline of the method employed to analyse the data from the transcripts of the qualitative interviews, including the process used for data reduction.

4.3.2 Data Reduction

The volume of data produced from the transcripts of the 30 key informant interviews was considerable; therefore it was essential for the researcher to identify a means of synthesising the key themes and significant points from the data in an effective manner. This process has been termed data reduction and is an integral part of data analysis as it 'sharpens, sorts, focuses, discards, or organizes data in such a way that 'final' conclusions can be drawn and verified' (Miles and Huberman 1994, p.11). Prior to undertaking data reduction, there is a need for the researcher to become fully immersed in the data, a process Ritchie and Spencer (2002, p.312) referred to as 'familiarisation'. In this thesis the involvement of the researcher in completing several of the verbatim transcripts and checking others against the original recordings facilitated this familiarisation stage.

The transcripts were prepared with large margins on both the left and right hand sides of the pages, enabling the researcher to detail the themes identified at the edge of the page close to the relevant text. During this process the interview transcripts were reviewed several times to identify and reaffirm the key themes present in the data. As a means of providing assurance that the researcher's interpretation of the interview transcripts was reliable, a colleague of the researcher who is an experienced qualitative researcher undertook a review of a sample of interview transcripts to verify the key themes identified. The feedback provided was that the themes recorded were considered appropriate. This was beneficial to the researcher as it was critical to ensure that a robust approach was applied to the data coding and subsequent analysis.

4.3.3 Selection of Data Analysis Method

4.3.3.1 FrameWork

The researcher initially planned to use '*FrameWork*' methodology (Ritchie and Spencer 1994) and software from the National Centre for Social Research (NatCen) to analyse the data from the qualitative interviews. The researcher undertook training on the '*FrameWork CAQDAS*' package to gain a greater understanding of its functionality but on trying to apply the tool in the context of this study, challenges were experienced as the researcher felt constrained principally because the identification of topic guides and themes, required by this approach, forced the researcher to identify a list of key themes which would then be applied to the transcripts as opposed to the themes emerging from the transcripts. Table 4.1 below provides an overview of the themes identified using the '*FrameWork*' methodology.

Table 4.1 Thematic Framework

Topic Guide	Index
Impact of devolution	Policies developed to meet local needs
	Divergence of health policy across UK
	Ministers are more accessible (positive)
	Ministers are more accessible (negative)
New supply	Positive impact of targets
	Negative impact of targets
	Financial investment
	Widening entry gate
	Better working conditions
	International recruitment
	HCSW route to registration
	Marketing of profession
<i>Student Attrition</i>	Lack of support in clinical placements
	Academic status (positive)
	Academic status (negative)
	Nursing seen as route to alternative career
Retention	Positive impact of Agenda for Change
	Negative impact of Agenda for Change
	Improving working lives / flexibility
	Workload
	Role diversity
	Pension
	Lure of working overseas
	Financial pressures / loss of posts
New roles	Support for Nurse Consultant
	Lack of support for Nurse Consultant
	Support for Modern Matron
	Lack of support for Modern Matron
	Impact of other professions on development of new roles e.g. Modernising Medical Careers
Policies	National policy successful
	National policy not successful
	Policy disconnect
	Impact of individuals
	Pace of policy change (positive)

Topic Guide	Index
	Pace of policy change (negative)
Workforce planning function	Strategy in place
	No strategy in place
	Effective processes
	Lack of effective processes
	Continuity
	Lack of continuity
	Support for profession based workforce planning
	Lack of support for profession based workforce planning
	Support for competency based workforce planning
	Lack of support for competency based workforce planning

The researcher likened this approach to pre-judging the outcomes of the analysis or forcing information gleaned from the transcripts into the pre-defined categories of the 'thematic framework' (Ritchie, Spencer and O'Connor 2003, p220). This is a commonly cited limitation of software packages for qualitative data analysis whereby the choice of software dictates how the researcher undertakes the analysis (Coffey and Atkinson 1996). Another shortcoming is that the relative ease of using software packages can encourage corners to be cut during the data analysis stages (Weitzman 2000).

The researcher therefore had to identify an alternative methodology for data analysis, which allowed more freedom in identifying the themes emerging from the interviewees' feedback and which was compatible with the principles of realist review and ensured an appropriate level of rigour.

4.3.3.2 *Mind Maps*

The alternative method adopted involved detailing the emergent themes on a series of mind maps which were then reviewed and analysed by the researcher and used to generate the findings as detailed in chapter six Analysis of Interview Data and Reporting of Findings.

Mind Maps were originally developed during the 1960s by Tony Buzan to enhance memory, concentration, creativity and learning skills (Buzan 1974; Buzan 1993). The use of mind maps has since evolved to include their role in both data collection and analysis in qualitative research (Brightman 2003; Tattersall, Watts and Vernon 2007; Meier 2007; Wheeldon and Faubert 2009; Tattersall et al. 2011). They are one of a range of tools which support the implementation of ideas mapping and the benefits of this compared with more traditional approaches to analysing qualitative data include the flexibility provided by the 'unconstrained structure' and the ability to 'create an association of ideas' (Davies 2011, pp.281, 282), whilst providing the 'visual ability to spot patterns, shapes and connections as a form of analysis' (Reason 2010, p.5).

Mind maps are valuable tools in developing a comprehensive understanding of the key concepts of the subject matter under review (Meier 2007), whilst encouraging 'a high level of critical thinking' (Brightman 2003, p.8). Additionally they enable the researcher to have greater control over the data analysis which is an important issue when analysing large amounts of complex interview material (Kvale 1996).

The mind mapping process begins with the documentation of the central issue being considered for example devolution. A particular strength of mind mapping over traditional 'code and retrieve' approaches to analysing qualitative data is the generation of inter-relationships between ideas including 'multiple perspectives, alternate realities [and] non-linear recording' of emerging themes. Furthermore mind mapping supports the on-going identification of linkages between data provided at any point during the interview whereas the 'code and retrieve' methods follow the order by which the data is recorded in the transcript (Brightman 2003, p.11).

4.3.4 Application of the Data Analysis Method

The process undertaken to transfer the key themes identified in the original transcripts onto the mind maps was to identify the broad topic areas and note these on the centre of the mind maps. A large A2 artist's pad was used to ensure there was sufficient space to develop the mind maps and to include as much detailed information as possible. Mind maps were developed for the following topic areas:

- devolution
- key health policies
- pace of policy change
- nursing workforce planning
- responsibility for workforce implications when policies are developed
- integration of workforce planning and centralised versus decentralised workforce planning
- recruitment and retention
- new roles / advanced practice
- Modernising Nursing Careers
- Agenda for Change
- graduate status.

These topic areas were chosen as they were in line with the key themes identified in the literature review (chapter three) or from the themes which emerged from the interview transcripts.

Data from the interviews from each of the four countries was recorded on the mind maps using the colour coding detailed below:

- England / UK-wide role – black
- Scotland - red
- Wales – blue
- Northern Ireland – green

The key themes identified were noted on the relevant mind map along with details of the interviewee's unique, anonymised code for example on the mind map relating to integration of workforce planning the following interviewees were recorded as having reported the need for better integration of workforce, service and financial planning: ENG04, ENG06, ENG08, ENG09, SC05 and NI01. This enabled the researcher to identify at a glance the key themes and trends emerging from the transcripts as well as relationships between themes, whilst the use of different colours created visual imagery highlighting the strength of a particular theme either within individual countries or across the UK. A photograph of the devolution mind map is included in Appendix XIV as an example for information.

When constructing the mind maps the researcher started populating each one with data from a different country, on a rotating basis, for example if the first mind map was initially populated with data from England then the next would be initially populated with data from Scotland and so on. The reason for this was to ensure that potential bias or dominance from any one country was minimised.

The process undertaken was that the interview transcripts for each country were reviewed and the key themes relating to the topic area of the specific mind map were documented in the relevant colour on that particular mind map. A tick was then placed on the transcript next to each theme documented on the mind map, thus avoiding duplication of the same information on different mind maps. Following completion of the mind maps, each transcript was reviewed to identify any key themes which had not been included on a mind map and a decision was then taken by the researcher to either include this information on a mind map or to exclude the data from the study.

The mind maps evolved and improved as the researcher became more confident and experienced with the process. The most challenging mind map

to complete was the key health policies map but this was principally due to the large number and diversity of responses to this line of questioning. The data analysis for this particular topic area was supplemented by the development of an excel table.

Following completion of all the mind maps, the researcher reviewed each individual mind map to develop the narrative which is detailed in chapter six Analysis of Interview Data and Reporting of Findings. As information from a mind map was documented in the relevant section of chapter six, a tick was recorded beside the source data on the corresponding mind map. This process was repeated until all the data was recorded in the text. Subsequently during editing phases throughout the development and refinement of this thesis, some of the data recorded was removed as it was determined not to be directly relevant to addressing the research questions posed in this thesis.

During the data analysis process consideration was given to the potential relationships between themes identified in the data and each interviewee's job role and / or employing organisation. The reason for this was to establish if particular responses or viewpoints were common amongst interviewees who were employed in similar roles or organisations, for example those who worked in professional organisations or trade unions. This review of the data did not identify evidence of strong associations between specific themes and interviewees from a particular role or employing organisation.

4.3.5 Reflection on the Data Transcription and Analysis Processes

Towards the end of the data transcription and analysis phases of this thesis, the researcher reflected on the methods used to identify if these could have been streamlined. On completion of the verbatim transcripts of the individual interviews the researcher sent a copy to each interviewee for verification. This created additional work for the researcher as it involved chasing interviewees for responses, although it did provide assurance that the

interviewees were in agreement with the data reported in an anonymised format in the thesis.

On reflection the data transcription, reduction and analysis phases of this study were more time consuming and onerous than the researcher had originally envisaged, however it was essential to the quality of this study that the processes were robust.

4.3.6 Summary of Key Points on Data Analysis

This section of the Research Approach Chapter detailed the process used for analysing the data in this thesis. The rationale behind the selection of mind mapping was explored, followed by an explanation of how the mind maps were developed and used to analyse the data from the 30 qualitative interviews.

4.4 Summary of the Research Approach Chapter

In summary this chapter outlined the research approach used in this thesis and it was subdivided into three sections. The first section of this chapter provided details of the research methods utilised in this study and the rationale for their selection. Critical realism was identified as the paradigm worldview combined with constructivist epistemology and realist ontology, whilst the underpinning theoretical lens was realist review. A mixed methods approach was used in this study and the primary source of data was the 30 qualitative key informant interviews with stakeholders from nursing, healthcare policy or workforce planning from across the four countries of the UK. This was augmented with two sets of secondary data; one from the analysis of healthcare policies (chapter two) and the other from the review of existing nursing workforce datasets (chapter five).

The second section of this chapter described the implementation of the research methodology including the selection of the purposive sample of 30 key informants. It outlined the process for developing and piloting the

interview schedule, planning and conducting the interviews and the transcription of the interview data.

The third section described the methods used to reduce and analyse the data from the transcripts of the 30 qualitative interviews, which involved constructing and reviewing a series of Mind Maps.

This chapter provided a detailed account of the research approach adopted in this study. The next chapter on Nursing Workforce Data (chapter five) will focus on the review of existing nursing workforce datasets which was undertaken to identify key trends in the data and to assess the impact of nursing and healthcare policies on the nursing workforce, over the period 1997-2009 and particularly to identify the impact of devolution.

Chapter Five - Nursing Workforce Data

5.1 Introduction

This chapter analyses nursing workforce data and provides some of the workforce context to the issues examined in the interviews. It outlines the changes and trends in the UK nursing workforce since devolution and provides detailed information on the profile of the nursing workforce at the time of the interviews in 2008.

A summary of nursing workforce data in each of the four countries is presented and key trends are identified. The data used is taken from a range of official sources including the NHS Information Centre England; Information Services Division (ISD), Scotland; Information Analysis Directorate, Department of Health, Social Services and Public Safety, Northern Ireland; Statistical Directorate, Welsh Assembly Government; Nursing and Midwifery Council (NMC) and Royal College of Nursing (RCN). Limitations of the available data are identified and gaps in the data are highlighted.

5.2 Background Information Regarding Nursing Workforce Data

Five main data-sets of nursing workforce data have been developed for this thesis. The first four data-sets were national data-sets from each of the four UK countries developed from information obtained from the government health departments in Scotland, Wales and Northern Ireland and from the NHS Information Centre, England. These datasets contained details of the Registered Nurses, Registered Midwives and nursing and midwifery support staff employed, principally within the NHS, in each of the four UK countries. The fifth dataset was UK wide and was derived from the Nursing and Midwifery Council (NMC) registrant database which provided details of Registered Nurses and Registered Midwives who were eligible to practice in the UK. The data from the NMC included Registered Nurses and Registered Midwives who were eligible to practice but who were not in employment along with some UK Registered Nurses and Midwives who were working overseas. The NMC data set included 'whole population' data for the

profession across the UK, and as such provided a backdrop to the more detailed country specific data.

The main focus of this research study was the registered nursing workforce; however inclusion of the non registered nursing workforce provided a profile of the total nursing workforce and an insight into changes in the composition and skill mix of the workforce over the period 1997-2008. The registered nursing workforce includes all Registered Nurses who have completed first or second level training. First level training is generally undertaken over a minimum period of three years and currently is based on a degree or diploma qualification. Second level registration²² involved a two year period of training but this level of preparation ceased in the UK in the mid 1980s. Subsequently a high proportion of second level Registered Nurses undertook conversion courses to become first level Registered Nurses. There are four recognised fields of nursing²³ on the NMC Register:

- Adult / General Nursing
- Mental Health Nursing
- Learning Disability Nursing
- Children's Nursing.

Another approach to delineating the registered nursing workforce is to use the NHS Agenda for Change²⁴ pay bands, with bands five to nine defining Registered ('qualified') Nurses and Midwives (Department of Health 1999b). The non registered nursing workforce, which includes Nursing Auxiliaries, Health Care Support Workers, Assistant Practitioners and Associate Practitioners, can be defined as the elements of the overall nursing workforce employed on Agenda for Change bands one to four.

²² Second level nurses were also known as Enrolled Nurses.

²³ a fifth for Registered Fever Nurses is now closed.

²⁴ Agenda for Change is the national pay system for the majority of NHS staff (excluding doctors and dentists). The pay bands range from 1 (lowest) and 9 (highest).

In the data analysis, it was not always possible to separate out the number of Registered Midwives or midwifery support staff from the nursing workforce data. Therefore midwifery information has been included in the datasets where it has not been possible to isolate the nursing workforce data. In order to provide an indication of the size of this workforce, the registered midwifery workforce in England represented approximately 7% of the registered nursing and midwifery workforce during the study period (NHS Information Centre 2009).

There was no uniformly agreed method for collecting nursing workforce data across the UK and separate systems existed in England / Wales, Scotland and Northern Ireland. Consequently it was more difficult to make direct comparisons between the four countries, for both the registered and the non registered workforce.

The workforce data published by each country is based on the number of staff in post (SIP) and predominantly reflects the nursing and midwifery workforce employed in the National Health Service (NHS), although attempts are now being made to expand data collection to include non NHS employers, particularly as increasing numbers of nursing staff are now being employed by Local Authorities and the independent sector. The data is generally obtained through the Electronic Staff Record (ESR) in England and Wales, the Scottish Workforce Information Standard System (SWISS) and the workforce census in Northern Ireland. There are limitations to the robustness of the workforce data, predominantly because it is dependent on the accuracy of staff records within NHS employing organisations, which may be incomplete or out of date. The reliability of the workforce data is however improving as the ESR and SWISS systems become more embedded within healthcare organisations. Prior to the introduction of the ESR and SWISS in 2006 and 2007 respectively, all workforce data was collected from annual or bi-annual workforce census or from independent payroll systems.

The NHS nursing workforce data is generally presented in two formats: one is headcount²⁵ which is the total number of people employed and the other is full time equivalent²⁶ (FTE) previously known as whole time equivalent (WTE). The ratio of FTE to headcount is an indicator of the level of part-time working, for example a ratio of FTE/HC=1 means that all staff work full time, whereas a ratio of FTE/HC=0.6 means that on average staff work 60% of the full time hours which in the NHS equates to 22.5 hours per week.

5.3 Overview of the Nursing Workforce Statistics and Trends (NHS data)

5.3.1 Rates of Workforce Growth

Table 5.1 below provides an outline of the full time equivalent numbers of Registered Nurses and Midwives in England, Scotland, Wales and Northern Ireland. The data is presented at three points in time, namely:

- 1999 representing a baseline position at the introduction of devolution
- 2004 five years after devolution
- 2008 when the interviews were undertaken.

²⁵ 'Headcount is literally a count of heads' (NHS National Workforce Projects 2005, p153).

²⁶ Full time equivalent (FTE) also known as whole time equivalent (WTE) 'is the standard method of defining the amount of work of an employee or in a position.....WTE is calculated by dividing contracted hours or contracted sessions by the standard hours (or sessions) for the grade' (NHS National Workforce Projects 2005, p193).

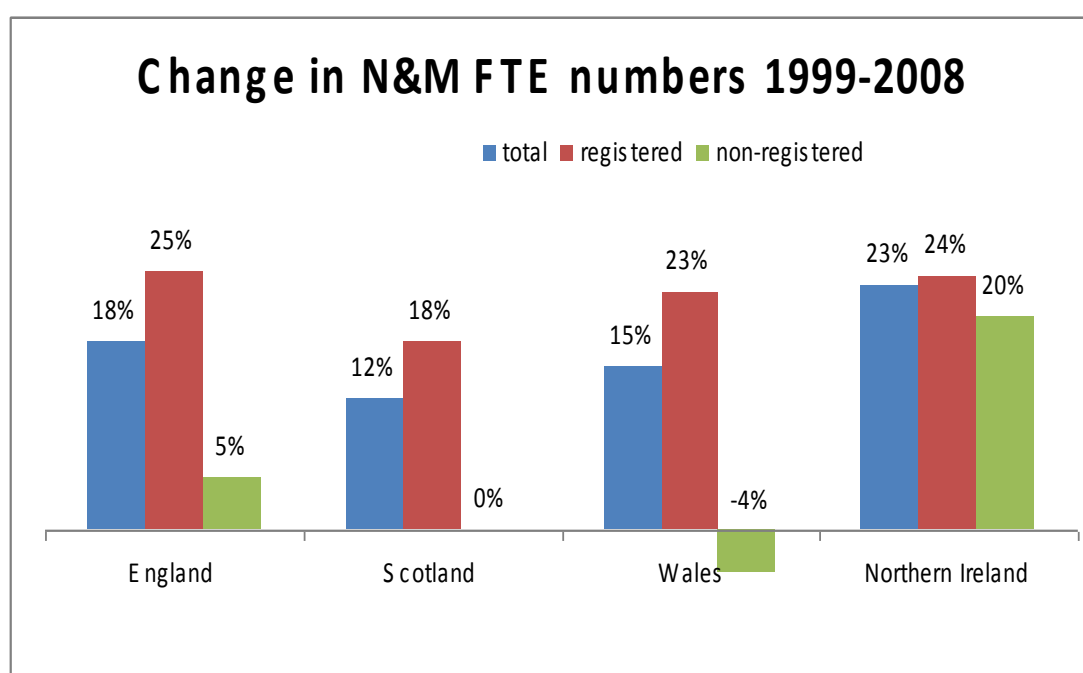
Table 5.1 The Nursing and Midwifery Workforce as at 1999, 2004 and 2008

	FTE 1999	FTE 2004	FTE 2008	% Growth 1999-2004 FTE	% Growth 1999-2008 FTE
England					
Registered	240,831	286,841	299,917	19%	25%
Non Registered	123,098	137,755	129,181	12%	5%
Total	363,929	424,596	429,098	17%	18%
% Registered	66%	68%	70%		
Scotland					
Registered	35,597	38,907	41,966	9%	18%
Non Registered	15,777	15,614	15,783	-1%	0%
Total	51,374	54,521	57,749	6%	12%
% Registered	69%	71%	73%		
Wales					
Registered	17,482	20,126	21,426	15%	23%
Non Registered	6,371	7,020	6,118	10%	-4%
Total	23,853	27,146	27,544	14%	15%
% Registered	73%	74%	78%		
Northern Ireland					
Registered	11,239	13,056	13,940	16%	24%
Non Registered	3,422	3,846	4,110	12%	20%
Total	14,661	16,902	18,050	15%	23%
% Registered	77%	77%	77%		

Sources of Data: NHS Information Centre England; ISD, Scotland; Information Analysis Directorate, DHSSPS, Northern Ireland; Statistical Directorate, Health Statistics Wales, Welsh Assembly Government Data excludes the non NHS workforce which is not routinely collected.

Overall the nursing and midwifery workforce employed in the NHS grew significantly over the period of the study. The rates of growth for the registered nursing and midwifery workforce were higher than the rates of growth for the non registered workforce, with variations across each of the countries. The percentage change in the registered and non-registered workforce is detailed in Chart 5.1 below.

Chart 5.1 Percentage Change in Nursing and Midwifery FTE (1999-2008)



The highest rate of growth in the registered nursing and midwifery workforce was in England with a 25% increase in FTE between 1999 and 2008, whilst Scotland had the lowest rate of growth in the registered workforce at 18%.

As noted earlier in this thesis, this growth in the nursing workforce was in response to policies that included specific targets to be achieved within defined timeframes. The *NHS Plan* in England (Department of Health 2000a) set a workforce target of an additional 20,000 nurses by 2004; however this target was exceeded, as the actual growth in headcount increased from 289,373 in 2000 to 336,615 in 2004 equating to an increase of 47,242

headcount. The increase in FTE over this time was 40,131 which was also more than double the original target set for the increase in headcount (NHS Information Centre). A later target for 35,000 nurses, midwives and health visitors by 2008 outlined in *Delivering the NHS Plan* (Department of Health 2002a) was achieved five years ahead of schedule.

In Scotland the *Partnership Agreement* (Scottish Executive Health Department 2003a) committed to bring 12,000 Registered Nurses and Midwives into the NHS in Scotland by 2007. The National Workforce Plan of 2006 reported that this target was close to achievement as 11,504 registered staff had been recruited into NHS Scotland between September 2002 and September 2005 (Scottish Executive Health Department 2006c). The manner in which the target had been presented left it open to different interpretations; as the focus was on recruitment numbers not net growth in the workforce. The workforce statistics for Registered Nurses and Midwives presented by the Information and Statistics Division (ISD) identified an actual increase of 3,031²⁷ in the registered nursing and midwifery headcount in Scotland over this period.

In 2002 the Health Minister in Wales committed to increasing the numbers of Healthcare Professionals in the NHS which included the announcement that 'by 2010 we will have planned for. . . 6,000 more nurses' (Welsh Assembly Government 2002). One year later the Wanless Review reported that this target was insufficient and estimated that, based on workforce planning data for 2002, there was a need for '+8,046' nurses by 2008 (Welsh Assembly Government 2003a, p.37). Subsequently *Wales: a Better Country* included a commitment for '3,000 extra nurses' however the deadline for delivery of this target was unclear as the policy implementation plan detailed that 'increased training of new nurses and recruitment policies should be delivered by 2006' (Welsh Assembly Government 2003b, p.30). The original target of '6,000

²⁷ During the period under review ISD workforce data for Scotland changed to reporting by Agenda for Change banding. Not all staff had been assimilated to AfC therefore a pro-rata assessment was used by the researcher. This would not have had a significant impact as there were only small numbers of staff awaiting assimilation.

more nurses' by March 2010 was again reinforced in *Designed for Life* (Welsh Assembly Government 2005a, p.75).

The registered nursing and midwifery headcount in Wales rose by 4,908 between 2003 and 2006 indicating that the commitment of 3,000 extra nurses had been exceeded. A press announcement in 2005 from the Health Minister informed that 'we are well on our way to meeting our targets of recruiting 6,000 more nurses' (Welsh Assembly Government 2005c), however by 2008 the overall registered nursing and midwifery headcount had reduced to 24,602 which was lower than the headcount of 25,821 in 2002²⁸. In common with the wording of the Scottish target, this nursing workforce target was open to mixed interpretations as recruitment of '6,000 more nurses' did not necessarily equate to a net growth of this level, and it was dependent on the start and finish dates being defined.

In Northern Ireland 'an estimated shortfall of 2,799 in the [nursing] workforce' was identified (Department of Health, Social Services and Public Safety and KPMG 2002, p.14) however no specific target was set for nursing workforce growth.

Overall there was a lack of detail provided on how the targets for nursing workforce growth were calibrated and whether the numbers identified were full time equivalents or headcount. It was also unclear if these targets included or excluded nurses in training. Generally the statements relating to the nursing workforce targets were vague.

The rates of growth for the non registered workforce were also variable. In Scotland the size of the non registered workforce in 2008 was broadly comparable to that in 1999. In Wales there was initially growth in the non

²⁸ Significant anomalies were identified between nursing and midwifery FTE and headcount data reported by Health Statistics Wales for 2007-2008 for both the registered and non-registered workforce. Enquiries made by the researcher uncovered that this was linked to a change in how data was recorded and prior to 2008 there was double counting of individuals who held substantive and bank contracts.

registered workforce, however overall the 2008 FTE figure was 4% less than the figure for 1999. This was accompanied by a more significant reduction of 26% in the headcount over the same period, signifying either a reduction in part-time employment or alternatively that there is an issue with the data quality²⁹. In England and Northern Ireland there was growth in the non registered workforce (FTE) of 5% and 20% respectively.

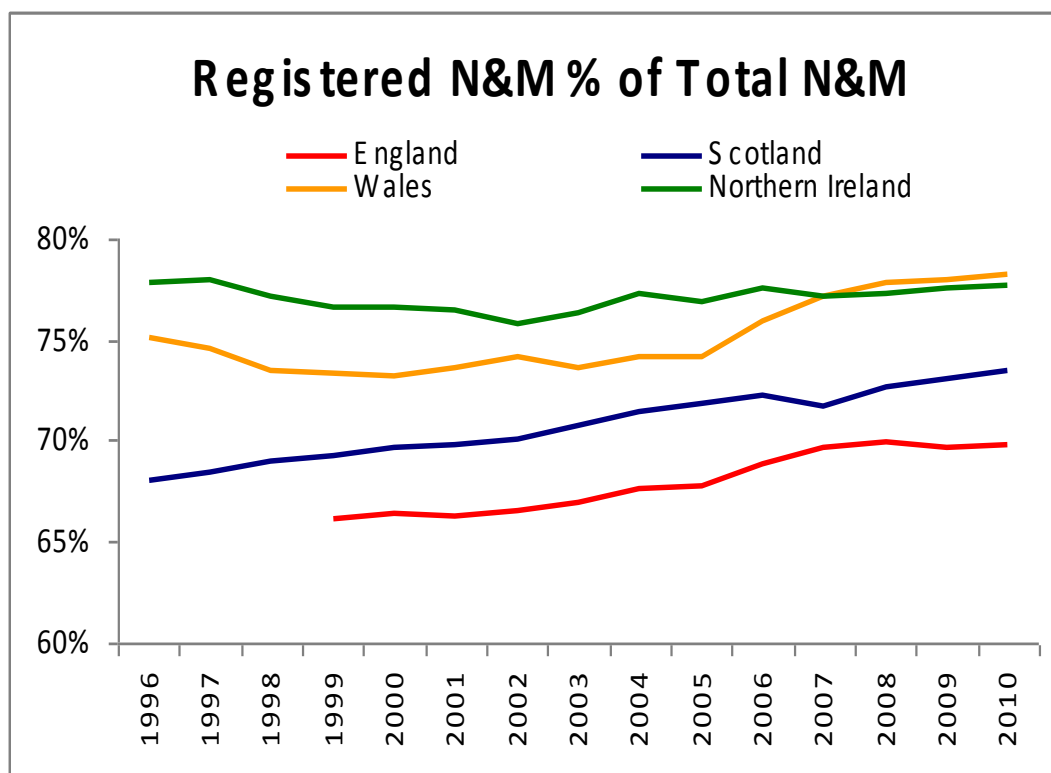
The data indicates that there was a variable but high level of growth in Registered Nurses across the period under review with lower rates of growth in the non-registered nursing workforce, resulting in a richer skill mix at the end of the study period than there was at the beginning. The different levels of staffing growth across the period under examination had not led to staff:population parity across the four UK countries. A report from the Nuffield Trust identified significant differences between countries in relation to the FTE nursing, midwifery and health visiting numbers per 1,000 population. England had the lowest levels of FTE/1,000 population whilst Scotland had the highest (Connolly, Bevan and Mays 2010).

5.3.2 Nursing Skill Mix

The proportion of Registered Nurses and Midwives as a percentage of the total nursing and midwifery workforce provides a measure of the skill mix. Higher percentages of Registered Nurses or Midwives represent a higher skill mix. Based on FTE figures in Table 5.1 above, the lowest level of skill mix was in England where the proportion of Registered Nurses was initially 66% in 1999 increasing to 70% by 2008. In Scotland it increased from 69% to 73%, Wales moved from 73% to 78% whilst in Northern Ireland it remained consistent at 77%. This meant that three of the four UK countries reported a trend of a richer skill mix across the period, as well as the numerical growth identified in all four countries. The trends in the percentage of Registered Nurses and Midwives in the total nursing and midwifery workforce are detailed in Chart 5.2 below.

²⁹ See footnote 27 above.

Chart 5.2 Registered Nurses and Midwives as a Percentage of Total Nurses and Midwives in FTE (1999-2008)



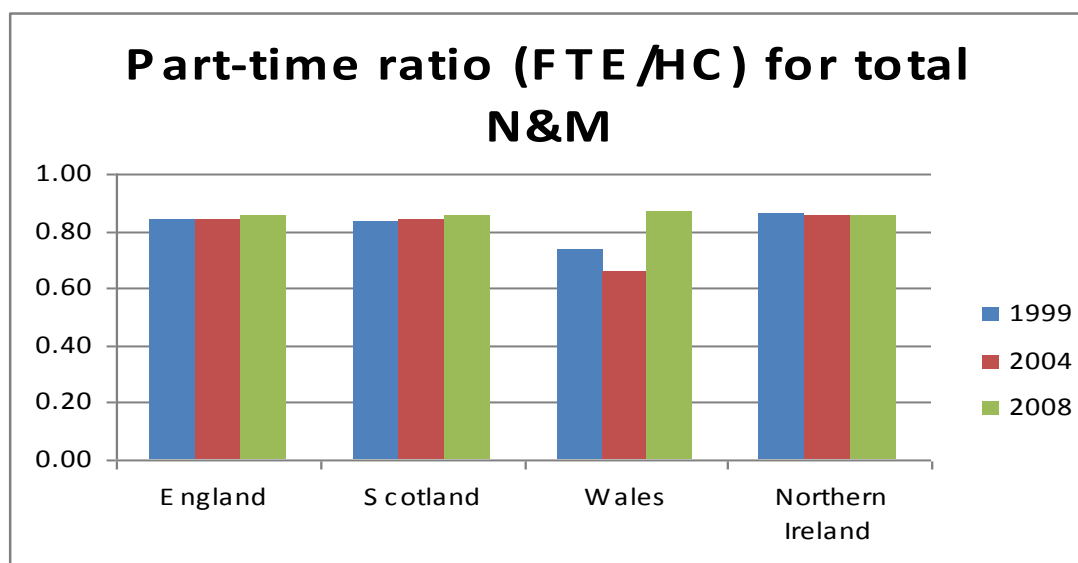
Data for England was not available in a consistent format prior to 1999.

Sources of Data: NHS Information Centre England; ISD, Scotland; Information Analysis Directorate, DHSSPS, Northern Ireland; Statistical Directorate, Health Statistics Wales, Welsh Assembly Government

5.3.3 Levels of Part Time Working

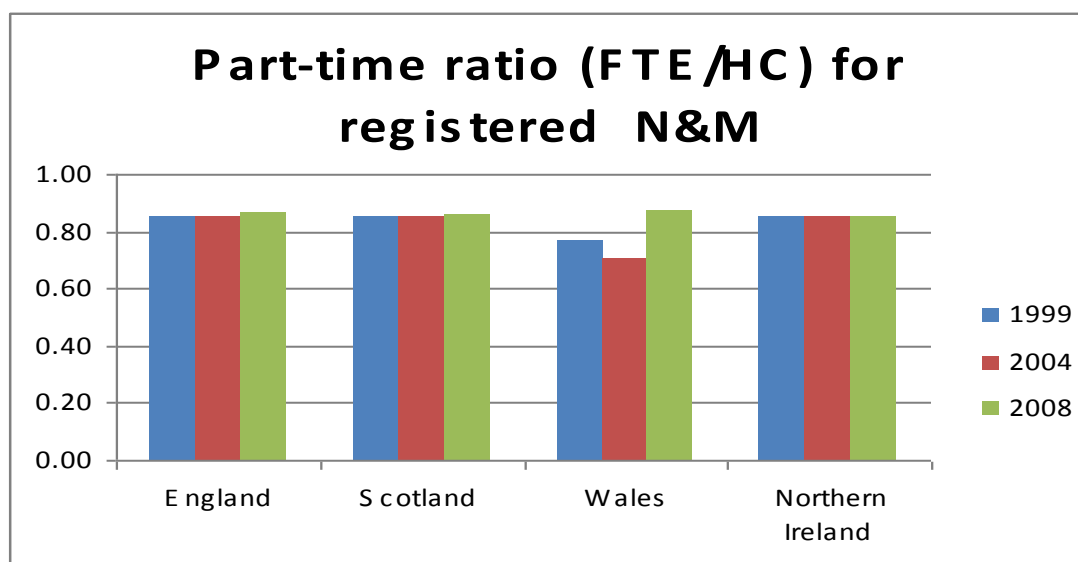
As mentioned earlier in this chapter the ratio of FTE to headcount provides an indication of the level of part-time working within an organisation or country. In general the lower the ratio the greater the rates of part-time working. Chart 5.3 details the trends in the FTE/headcount ratio for the total nursing and midwifery workforce and Chart 5.4 details the trends in FTE/headcount ratio for the registered nursing and midwifery workforce.

Chart 5.3 Trends in FTE/HC Ratio for Total Nursing and Midwifery Workforce



Sources of Data: NHS Information Centre England; ISD, Scotland; Information Analysis Directorate, DHSSPS, Northern Ireland; Statistical Directorate, Health Statistics Wales, Welsh Assembly Government

Chart 5.4 Trends in FTE/HC Ratio for Registered Nursing and Midwifery Workforce



Sources of Data: NHS Information Centre England; ISD, Scotland; Information Analysis Directorate, DHSSPS, Northern Ireland; Statistical Directorate, Health Statistics Wales, Welsh Assembly Government

The two sets of data showed broadly similar trends in the FTE/headcount ratio. The data indicated that the part time working rates were either the same or lower for Registered Nurses and Midwives when compared with the total nursing and midwifery workforce. In 2008 the FTE/headcount ratio for the total nursing and midwifery workforce was 0.85 in both England and Scotland, 0.86 in Northern Ireland and 0.87 in Wales.

Initiatives across the four UK countries to increase part-time working such as the *Improving Working Lives* policy initiative, *Delivering the NHS Plan – Next Steps on Investment, Next Steps on Reform* (Department of Health 1999d, 2000b, 2002a) and the *Family Friendly Guidelines* in Scotland (Partnership Information Network 2000) did not appear to have had a significant impact in terms of any overall increase in the rate of part-time working based on the evidence of these statistics.

The data from Wales which apparently shows that the FTE/headcount ratios fluctuated over the period of the study may reflect issues with data accuracy related to the 2007-2008 headcount.

5.4 Profile of the Registered Nursing and Midwifery Profession (NMC data)

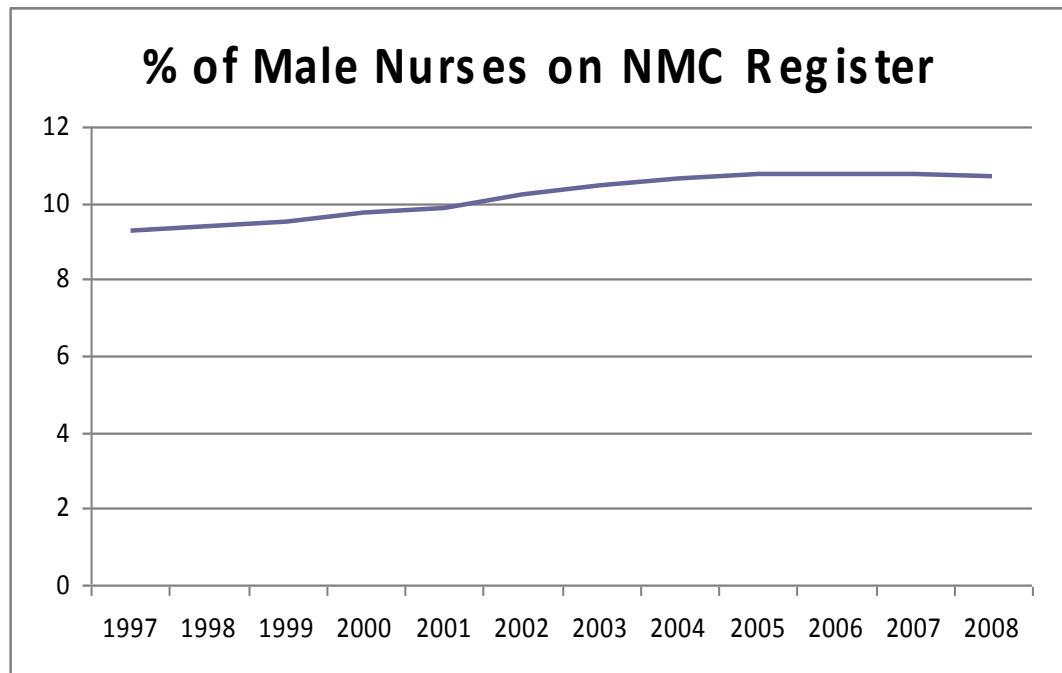
The Nursing and Midwifery Council is the UK wide professional regulator of Registered Nurses and Midwives. The NMC publish the statistical analysis of the registrant database on its website annually³⁰ (NMC Statistics). The dataset includes an overview of the gender and age profile of Registered Nurses and Midwives; a breakdown of the numbers of nurses on each branch or field of the register; details of the numbers of nurses and midwives entering the register, including country of origin; the numbers of nurses and midwives leaving the register and an indication of the numbers of nurses and midwives who are considering overseas employment as a nurse or midwife.

³⁰ The NMC stopped publishing this annual data in 2008.

5.4.1 Demographics of the NMC Register

The majority of Registered Nurses and Midwives are female and the proportion of men on the register increased only marginally from 9.27% in 1997 to 10.69% in 2008, as detailed in Chart 5.5 below.

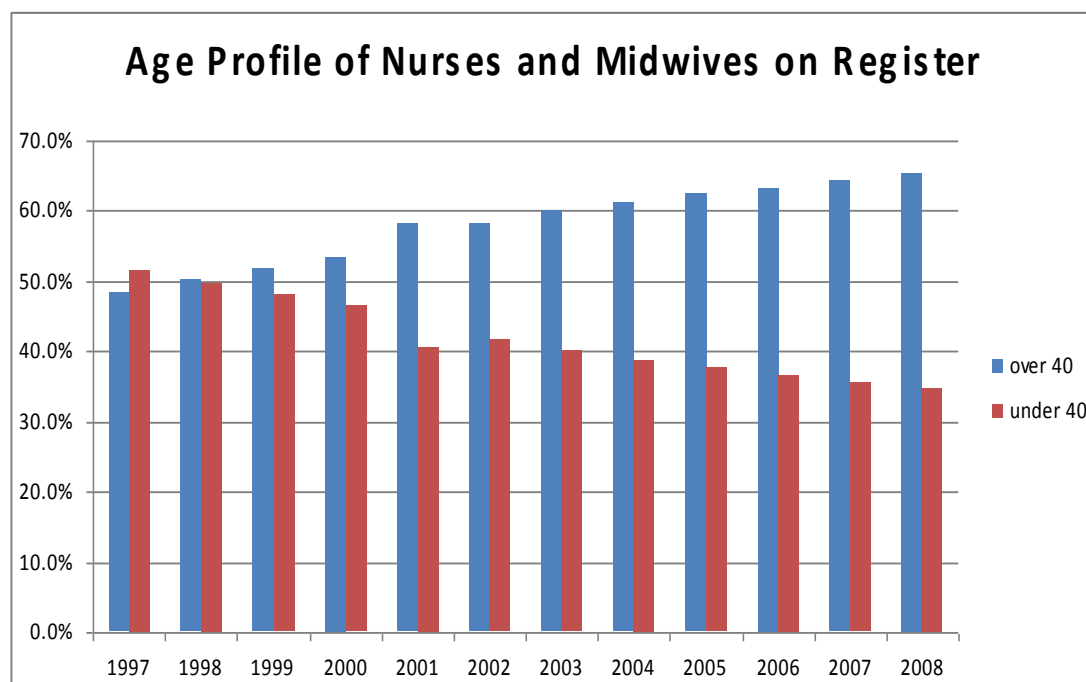
Chart 5.5 Trend in Percentage of Nurses on NMC Register Who Were Male (1997-2008)



Source of data: NMC

The average age of the nursing and midwifery workforce is increasing and Chart 5.6 below demonstrates that since 1998 the numbers of Registered Nurses and Midwives on the register who were over 40 years of age is larger than those who were under 40 years of age. This gap has continued to grow resulting in the position whereby in 2008, 65.4% of those on the register were aged 40 and over, whilst 34.6% were under the age of 40 years.

Chart 5.6 Percentage of NMC Registrants Aged Under and Over 40 years (1997-2008)



Source of data: NMC

There were several reasons for this increasing age profile of the nursing and midwifery workforce including:

- the growth in the nursing numbers and the overall increase in the percentage of mature entrants, partly through widening access programmes, including secondments for Health Care Support Workers to undertake nurse training
- Return to Practice Programmes encouraging nurse who have taken a career break to return to the workforce
- increased numbers of overseas nurses, many of whom have worked for a period of time in their country of origin prior to applying to work in the UK.

5.4.2 Profile of those Joining the NMC Register

When devolution was introduced in 1999, the annual number of initial registrations, from the UK and overseas, recorded by the NMC was 17,954.

Five years after devolution in 2004 the number of initial registrations was 34,617, whilst at the time of the interviews in 2008 this figure was 25,864. The numbers of new nursing and midwifery registrants grew year on year from 1999 to 2004 following which there was a gradual decline.

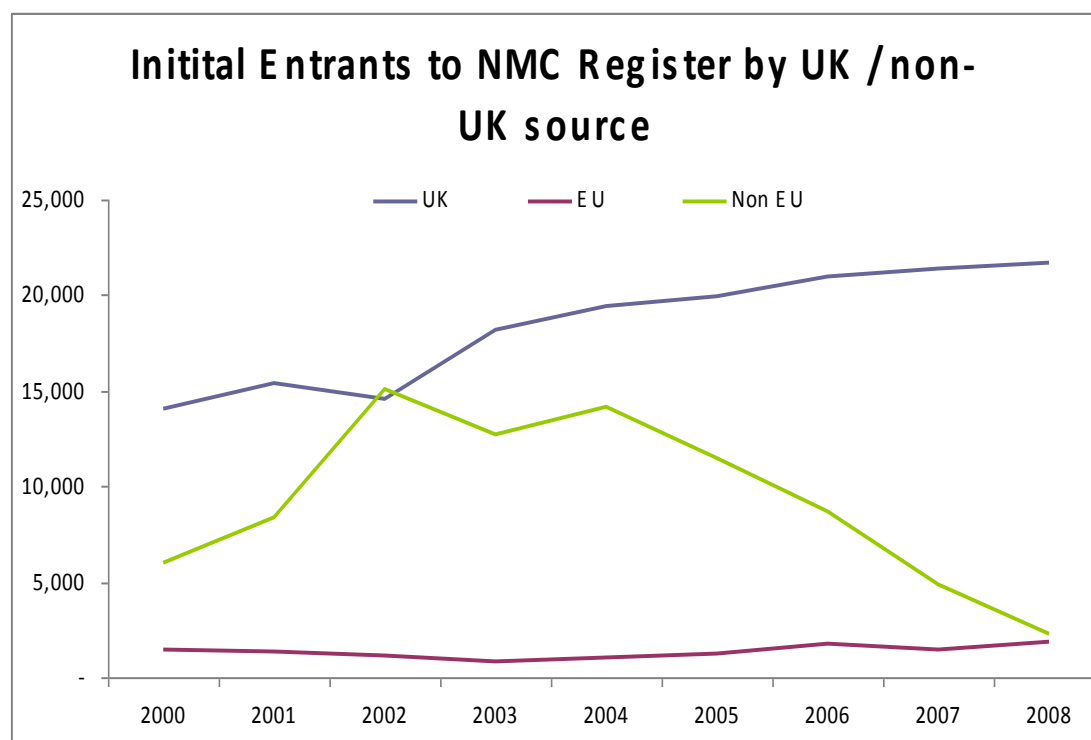
Growth in nurses and midwives registering from overseas rose significantly over the period 2000-2002, particularly those from non European Union countries. In 2002, 49% of all initial registrants to the NMC register were from overseas (outwith the European Union). This influx of nurses from overseas was related to the significant expansion of the nursing workforce in response to the need to meet growth targets as discussed above. International recruitment from outwith the European Union was predominantly from South Africa, Philippines, Australia and India.

Chart 5.7 below provides details of the initial registrations³¹ to the NMC from the UK, European Union and from countries outwith the European Union. After 2004 the supply of nurses from countries outwith the European Union rapidly declined. There are several reasons for this including:

- achievement of the *NHS plan* targets for nursing workforce growth
- growth in supply of Registered Nurses from training programmes within the UK
- constraints on NHS funding
- changes to immigration rules and the occupation shortage register limiting movement of nurses from non European Union countries.

³¹ Only new registrants have been included, subsequent registrations have been excluded.

Chart 5.7 Initial Entrants to NMC Register by Source



Source of data: NMC

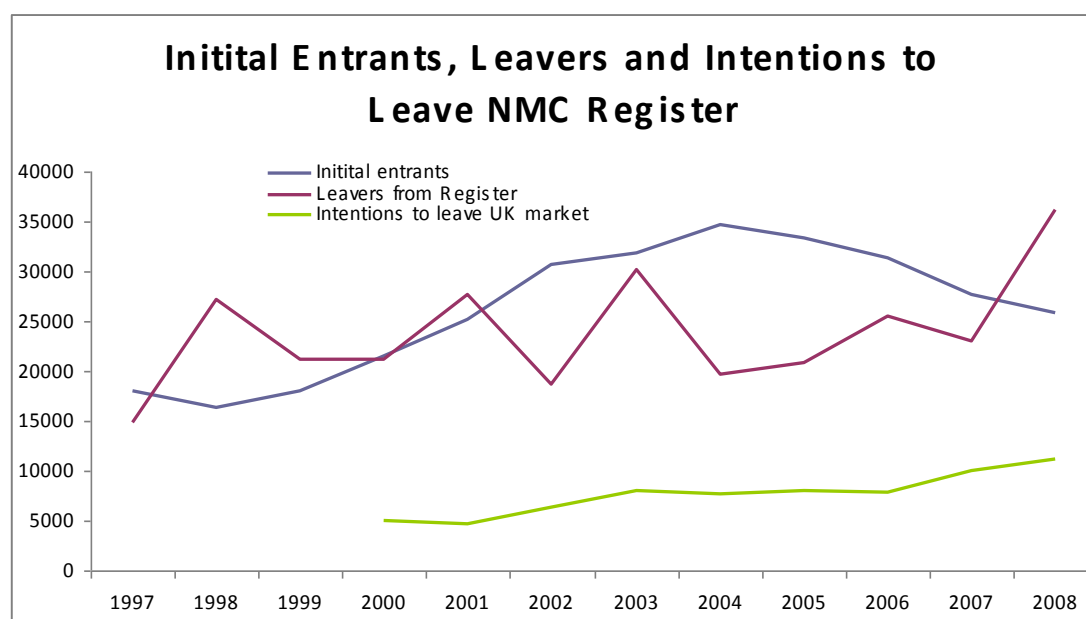
5.4.3 Joiners, Leavers and Intentions to Leave NMC Register

The number of nurses and midwives leaving the NMC register was at an all time high in 2008 when the number leaving was reported to be 36,203 whilst the number joining was 25,864.

The number of requests from overseas for verification of registration, which shows intention to leave the UK was 11,178 in 2008.

Chart 5.8 shows trends in new entrants, leavers and verifications for possibly leaving the UK, across the period 1997-2008. This shows that at the time of the interviews there had been a few years of year on year decline in new entrants, a steady rise in verifications to move outside the UK and an apparent spike in leavers in 2008.

Chart 5.8 Initial Entrants, Leavers and Intentions to Leave the NMC Register



Source of data: NMC

5.5 Limitations of Available Datasets

There were several limitations with the data reported including:

- the inclusion of midwifery and health visiting data across all the data sets, where it was not possible to exclude these components. Owing to the relatively small numbers in these professional groups the researcher does not consider the impact of this to be significant
- where data had been derived from the electronic staff record (ESR), the reliability of this data was variable depending on the accuracy of individual staff records and the collation of information (official NHS data source in each country)
- the official NHS data from some countries included nurse bank staff whereas data from other countries excluded this source
- the change in how the NHS in Wales presented information made it problematic to make comparisons between datasets pre and post 2008

- the dataset from the Nursing and Midwifery Council (the UK wide regulator) was derived from the registrant database which has limitations as supplying data and information for workforce planning is not considered to be the core business of the regulator
- there was a delay between the recording and publication of nursing workforce data which applied to all the datasets reviewed.

In addition to these limitations with the nursing workforce datasets, there were also gaps or inadequacies in the available datasets including:

- the absence of a clear UK wide overview of the nursing workforce principally because there is a lack of consistency between the datasets from each country. The majority of the nursing workforce data was drawn from four different data sources – the NHS ‘official’ source for each UK country. The fact that some information is coded and reported in different formats made some UK wide comparisons problematic or possibly inaccurate. An example of this was the lack of consistency in the staff groups reported under the categories non registered, non qualified or support to nursing and medicine
- not all the data was readily available across each of the four countries, for example staff in post or establishment data by Agenda for Change banding or employment category (four country official NHS data sources)
- limited reliable data regarding the first employment destination of nurses and midwives following initial registration
- a lack of data concerning employment of nurses outwith the NHS
- insufficient information regarding why nurses leave the NHS or why their registration has lapsed.

Despite the limitations listed, the nursing workforce data reported in this study has been used to identify trends in the nursing workforce and to complement evidence in other reports and studies. The value or usefulness of the nursing workforce datasets was not explored as an explicit line of

questioning during the interviews nor was it raised specifically by the interviewees.

5.6 Summary of Key Points

This chapter provides an assessment of the profile of the nursing workforce at the time of the fieldwork, and identifies key trends and issues that were examined during the interviews including:

- substantial levels of growth in the registered nursing and midwifery workforce in the four UK countries ranging from 18-25% and in the total nursing and midwifery workforce in the range of 12-23%
- richer skill mix in three of the four countries³² in 2008 than in 1999
- differences in the skill mix of the nursing workforce in 2008, with 70% of the nursing and midwifery workforce in England being registered, the lowest skill mix in the UK, compared to 78% in Wales which was the richest skill mix
- across the four UK countries the part-time ratio of FTE/headcount was broadly static across the period, indicating little evidence of increased rates of part-time working over the period under review
- the overall nursing workforce was aging and the average age of students entering pre-registration nursing programmes had increased
- the consistently low proportion of male nurses in the UK compared to the total registered nursing population, ranging from 9-11% of registrants
- the significant overall contribution of international recruitment in increasing the numbers of nurses
- a period of substantial growth in the nursing workforce from 1998 to 2004, was followed by a tailing off of expansion. In 2008 there was a spike in the number of nurses leaving the profession or signalling their intention to work overseas.

³² Skill mix in Northern Ireland was consistent across the period 1999-2008.

The key findings of the analysis in this section of the thesis will be referred to in later chapters, where the nursing workforce data will be used as an indicator of policy outcomes or to illustrate points made by interviewees during the interviews.

Chapter 6 Analysis of Interview Data and Reporting of Findings

6.1 Overview of Analysis of Data and Reporting of Findings

This chapter will report the main findings from an analysis of the qualitative data obtained from 30 in-depth key informant interviews. This will be supplemented with relevant and related information from the policy analysis, literature review and from the analysis of the nursing workforce data, to illustrate key points and counterpoint issues raised during the interviews. This chapter is structured in line with the conceptual framework and literature review whereby the data analysis will be reported under the following headings:

- devolution
- key health policies
- nursing workforce planning
- nursing recruitment and retention.

Although interviewees were asked to reflect over the period since devolution was introduced in 1999, the data presented comes from the point in time when the interviews were undertaken in 2008. The memory recall of interviewees will have been influenced by the roles they have held over the period under review and the different experiences they have had in relation to nursing workforce policy and planning.

Throughout this chapter, when reporting responses from interviewees, the format used has been to provide an overview of the key themes from across the UK. This UK overview has been followed by a review of the specific findings within each of the four countries, where there was significant information or areas of divergence to report.

As explained in the Research Approach (chapter four), semi-structured interviews were used to gather information and consequently not all interviewees were asked exactly the same set of questions. This approach

enabled the researcher to tailor questions to the contexts of the interviewee's country and employing organisation. Additionally, where there was saturation of information, new lines of enquiry were pursued rather than repeatedly asking questions which resulted in the same responses (Morse 1995).

This approach resulted in a dataset where issues of key importance within an individual country could be explored resulting in a more detailed understanding of the emerging themes and priority issues. A consequence of this was that it was not always possible to provide a collated response from all 30 interviewees for each issue reported; instead it was only feasible to provide an indication of the strength of a response. This was however consistent with qualitative interviewing which is aimed at gaining an in-depth understanding of an issue as opposed to merely breadth of information (Silverman 2000) and to gain insight into how things work in particular contexts (Mason 2002).

6.2 Devolution

6.2.1 Setting the Context

Devolution was the first of the four main headings used in analysis and presentation of findings. As highlighted in the literature review there had been limited research undertaken into devolution in the UK, which has tended to focus on broad issues such as constitutional change, politics and public policy, including healthcare, in the devolved administrations. The impact of devolution specifically on nursing workforce policy and planning is an area which had not been investigated, therefore one of the key research questions the researcher aimed to address in this thesis was:

- *What has been the impact of devolution on nursing workforce policy and planning across the four countries of the UK (1997-2009)?*

The transcripts of the key informant interviews were analysed to identify issues of significance both within the devolved administrations and between

the devolved administrations and England. The reporting of findings on devolution are examined within the broader context of the findings of programmes of research into devolution and health (including Hazell and Jervis 1998; Jervis and Plowden 2000; Jervis and Plowden 2001; Greer 2001; Jervis and Plowden 2003; Greer 2003; Greer 2004b; Greer and Rowland 2007; Greer and Trench 2008; Jervis 2008; Connolly, Bevan and Mays 2010).

This section will cover the following:

- the impact of devolution upon nursing
- policy divergence as a consequence of devolution
- the implications of policy divergence on nursing
- sharing of best practice
- nursing leadership in the four countries, including *Modernising Nursing Careers* (Department of Health et al. 2006) as a case study in collaboration
- the power bases of individuals and professional organisations / trade unions
- summary of key points.

6.2.2 The Impact of Devolution upon Nursing

A total of 14 interviewees cited examples of increased flexibility of policy response to local health needs as a direct result of devolution, with feedback including statements such as there is scope to '*think outside the box*' (SC01), to '*do things differently*' (ENG09), to be more responsive through quicker decision making (SC02, SC03, NI01) and it has resulted in '*a greater understanding about what your population needs are and what your local healthcare providers do*' (SC03), enabling decision making closer to where you work and deliver services (ENG05, NI05). Devolution was seen as a useful force (ENG01), '*a catalyst for all the great initiatives over the past decade*' which has created a strong national identity (SC01), '*a real buzz within nursing*' (WAL03) and has been '*tremendously successful*' (WAL01). It

shows people that things can be done differently (ENG03, WAL02) and this desire to be different has created '*a richness*' (ENG01). An interviewee remarked that the devolved administrations were '*very healthy*' (ENG06), whilst another reported that there is '*nothing more liberating than your vote counting for something*' (NI02). Five of the 14 interviewees who commented on the responsiveness of the devolved administrations were from England indicating that this viewpoint had also been formed by some who did not work in the devolved administrations. Although the line of questioning used in the interviews was to establish the impact of devolution specifically upon nursing, a number of the responses provided were more general and related to devolution's broader impact upon health.

13 interviewees from across the four countries were explicitly positive about the impact of devolution upon nursing (ENG01, ENG04, ENG06, SC01, SC07, WAL01, WAL03, WAL05, NI02, NI03, NI04, NI05, NI06). One interviewee specifically commented upon the benefits from devolution for nursing workforce planning in Northern Ireland, reporting that following devolution it was easier to obtain increased funding for pre and post-registration nurse training (NI05). Four interviewees, who were explicitly positive about devolution, reported that devolution brought clarity of responsibility and accountability (ENG04, ENG06, SC07, NI02) with '*the devolved administrations quite rightly taking responsibility . . . and doing things that suit them*' (ENG06), as opposed to being directed by England (NI01).

In Northern Ireland five of the six interviewees reported the positive impact of devolution upon nursing which was a higher rate of response than reported in Scotland or Wales, the other two devolved countries. This may have been due to the fact that following a period of suspension; devolution was re-introduced to Northern Ireland in May 2007, one year prior to the interviews undertaken for this study. This meant that at the time of the interviews

devolution was a much newer reality for interviewees in Northern Ireland than those in Scotland and Wales who had nine years experience of devolution.

Five interviewees from England commented upon the negative implications of devolution (ENG02, ENG07, ENG08, ENG09, ENG10). One of the five interviewees (ENG09) provided positive and negative views on the impact of devolution upon nursing, whilst the other four only provided negative comments. These viewpoints included highlighting the potential for differences in healthcare standards (ENG02) and the impression that devolution had made collaboration in nursing policy and practice more difficult across the four countries (ENG10). Two interviewees cited challenges in relation to the different responses to the implementation of the 2007 pay award for nurses, which resulted in disparity between the devolved countries and England (ENG08, ENG09). One interviewee questioned whether devolution could be justified and '*whether there is any benefit from it?*' (ENG07). All five of the interviewees who commented on the negative impact of devolution upon nursing were from England and their viewpoints were therefore formed from indirect experience of devolution.

Some interviewees reported that freedoms associated with devolution had enabled the development of nursing roles in line with their specific policies and to meet the needs of their patients. For example Wales developed its own approach to the creation of Nurse Consultant roles (WAL02), whilst England was the only country to introduce the Modern Matron role (Department of Health 2000a; 2001b) and at the time of the interviews Scotland was developing a new model of Community Health Nurse (SC04, SC06) that the other three countries were not.

In summary 14 of the 30 interviewees reported that following the introduction of devolution there was an increased ability for government health departments in individual countries to be more flexible and responsive to local healthcare contexts; 13 interviewees indicated that in their view

devolution has had a positive influence specifically on nursing, whilst 13 made no comment on this. The five interviewees who commented on the negative impact of devolution on nursing were all from England.

6.2.3 Divergence as a Consequence of Devolution

One of the key themes which emerged from the literature review (chapter three) was the extent of divergence in health policies after devolution. This section reports the findings from the key informant interviews on the extent of divergence in health and nursing workforce policy across the four countries following devolution. It also examines the impact divergence has had on nursing and the implications for sharing good practice.

Two interviewees reported that prior to devolution there were some flexibilities within the system but the political climate since devolution had meant that there was more likelihood of these opportunities being exploited (SC05, NI05). The majority of interviewees did not explicitly acknowledge the flexibilities that existed in relation to health policy prior to devolution. This may have been related to how these flexibilities were used before devolution or the level of exposure interviewees had to the systems in place pre devolution. Paun and Hazell acknowledged that the autonomy of the Scottish, Welsh and Northern Ireland Offices (pre-devolution) was limited as these were 'being managed by territorial departments of the unified British government' (2008, p.3).

An interviewee from England stated that before devolution broad assumptions could be made about health policy across the UK with the caveat that there may have been some minor differences in Scotland or Wales (ENG06). However since devolution different healthcare systems had been created across the UK due to the divergence in health policies between the four countries (ENG06, ENG07). These viewpoints were consistent with the findings from the Constitution Unit's earlier study on devolution which highlighted that although health policy divergence predated devolution it had

'substantially increased' following devolution (2005, p.10). Furthermore Greer noted that devolution in the UK was considered to be working "best' if it produces divergence and separation between systems' (Greer 2007, p.87).

Another interviewee from England noted that through this policy divergence there will be '*a richness that happens through the desire to be different in different parts of the UK . . .*' (ENG01). This statement was in line with one of the findings from the Nuffield Trust report on Devolution and Health which described devolution as creating opportunities for the health services in each country to 'continue to evolve to meet local and national need' whilst 'enabling all the UK's health services to observe and, where appropriate, mirror or adapt good practice to suit the needs of their own populations' (Jervis 2008, p8).

6.2.3.1 Policy Divergence across the Four Countries

The differential impact of devolution within Scotland, Wales and Northern Ireland will now be examined in more detail. Two interviewees from England reported the viewpoint that devolution had impacted more upon health and nursing issues in Scotland, Wales and Northern Ireland than it had on England (ENG03, ENG10). The reason they cited for this was that the smaller size of the devolved administrations of Scotland, Wales and Northern Ireland made it easier for changes to be implemented (ENG03, ENG10), whilst it was acknowledged that the larger size of England and its '*north / south divide*' were barriers to change. This '*north / south divide*' in England was specifically described as being:

'the real distortion . . . which seems to be being caricatured at the moment that everyone in the north must be terribly smart because they are balancing their books and everyone in the south must be stupid because they can't' (ENG03).

This definition of the north / south divide is different to the usual use of the term, which generally refers to the north of England as having less money compared with the more affluent south of England. The quote from the interviewee highlights specific challenges with NHS funding in the south of

England which may have been related to issues such as insufficient budget allocations, increased demand for services or excessive temporary staffing costs due to recruitment challenges.

Another interviewee in England reported that a further area of policy divergence was that there was considerably less involvement of the private sector in health service delivery within the devolved countries than existed in England (ENG05). In their view this was principally due to the '*choice and competition*' policy agenda which was unique to the English political context (ENG06), whereby a range of service providers were encouraged to compete for NHS business. This comment was consistent with the findings of several commentators on devolution who highlighted England's healthcare policies promoting competition, plurality of provider and Foundation Trusts as differentiating it from the other three UK countries (including Greer 2004a; Keating 2005b; Chartered Institute of Public Finance and Accountancy 2008; Greer and Trench 2008; Harker and Oppenheim 2010).

Prior to its introduction, devolution was of high importance on the political agenda in Scotland and attracted widespread public support. Scotland has since been referred to as 'the star case of devolution' as the essential criteria regarded as being critical for success were in place, which included being 'long-prepared, popular, supported by an overwhelming coalition, and freed from the legal restraints and institutional complexities that hamper Northern Ireland and Wales' (Greer 2004a, p.63). This was reflected in the feedback from one interviewee from England who acknowledged that at the introduction of devolution, Scotland was:

'probably in a better position to hit the ground running because it was a concept that the country believed in, it wasn't just something that was being driven by Westminster' (ENG05).

Another interviewee, from Scotland, described devolution as being '*the confidence in the country to do what is felt to be right from a health policy perspective for the people of Scotland*' (SC04), particularly in relation to addressing the country's health and illness profile; developing local solutions

for local needs and the creation of opportunities for greater public involvement and engagement (SC04). Since devolution, there is evidence that Scotland has distanced itself from Westminster policies (Kerr and Feeley 2007; Lang 2007) and an example of this was the decision to abolish NHS Trusts in Scotland and replace these with unified Health Boards.

A lack of policy making capacity was identified as a deficit in Wales in the early stages of devolution, although the cohesiveness between Welsh Ministers and the Assembly infrastructure, at this time, was acknowledged as a positive attribute (Parry 2003). One interviewee highlighted the strong sense of national identity in Wales (WAL03), whilst another interviewee expressed frustration at the constraints of having to reach four country agreements on some issues such as the regulation of new nursing roles (WAL05). A further challenge highlighted by one interviewee was the dominance of England's voice in relation to discussions on professional regulation, where it was difficult to ensure that the specific requirements of Welsh health policy were being considered (WAL02).

Following 30 years of civil conflict in Northern Ireland, devolution was reported by one interviewee from Northern Ireland as being much more of a political settlement which benefited the people of Northern Ireland in the 'sense of peace' (NI06). One of the difficulties has been that after an initial period of devolution in Northern Ireland, there was a reversion back to direct rule from October 2002 until May 2007. As a result of this intermittent devolution, one interviewee from England reported that progress in Northern Ireland has been more difficult to judge (ENG05), whilst an interviewee from Northern Ireland described devolution as being 'very precious' even if it 'is flawed . . . now I say it's flawed because our politicians have been bred in sectarian politics for the past how many decades . . .' (NI02). There was a perception that under direct rule:

'things would be marched forward, more swiftly in a sense . . . if a decision was to be taken there was more likelihood that it would be taken without listening for quite so long to all views' (NI01).

When the Assembly in Northern Ireland was re-instated there was '*an awful lot of influencing going on where people would be coming and lobbying*' (NI01) and '*one of the things we addressed was the proposed English healthcare system and [the fact that] it's not fit for purpose in Northern Ireland*' (NI03). A consequence of this increased influencing activity was a more protracted policy and decision making processes (Campbell 2007). The slower pace of policy implementation in Northern Ireland could also be attributable to the D'Hondt system and the need to consult with several political parties when developing healthcare policies.

An interviewee from England suggested that lessons should be learned from the experience of Northern Ireland in integrating its health and social care services, which predated devolution (ENG05). Three interviewees from Northern Ireland noted that they were further ahead on integration of health and social care in comparison to the other countries of the UK (NI01, NI02, NI06). However interviewees from Northern Ireland cited delays in establishing care packages for patients being discharged from acute hospitals (NI04) and inequities in pay between health and social care staff, with reports of social workers receiving higher pay bands than nursing staff undertaking similar roles (NI02, NI03).

Overall several interviewees expressed the view that health policy divergence existed following devolution, particularly divergence between Scotland and England. Wales had begun to produce more policies to address the health needs of its local population, whilst Northern Ireland was still coming to terms with the political change and was preoccupied by the opportunities for consulting with the local population and responding to local needs.

6.2.3.2 The Implications of Policy Divergence on Nursing

This section explores the specific implications of policy divergence on nursing. Interviewees were asked their views on the impact of devolution

upon nursing. In response to this line of questioning, 11 interviewees raised the impact of policy divergence upon nursing and the range of responses is reported in this section. The remaining 19 interviewees did not specifically mention the impact of policy divergence on nursing.

An interviewee from England stated that the divergence in healthcare policy across the four countries had undoubtedly resulted in the creation of '*very different healthcare systems and that must have significant implications for the workforce*' (ENG07). A further two interviewees, also from England, identified that devolution posed a challenge for the nursing profession as the UK countries were developing different approaches to nursing workforce policy and planning (ENG04) and it was becoming harder to transfer good practice or share ideas (ENG09). One interviewee in Scotland stressed that nurses across the UK wanted to be treated equitably and as a cohesive nursing workforce (SC02), whilst another in Wales, highlighted that it was very hard for nurses to work across borders if each country has or was moving towards different professional and policy frameworks, which could limit their mobility now and in the future (WAL02). This raises an important point that as the devolved administrations mature and continue to develop new nursing roles, there is an increasing risk to the future applicability of UK-wide regulation and professional education which are currently reserved matters.

A notable difference in nursing policy across the four UK countries at the time of the interviews was that there was graduate entry to pre-registration nurse education programmes in Scotland, Wales, and Northern Ireland but not in England. Wales was the first country to go '*all graduate*' and this policy was introduced in its Nursing Strategy (National Assembly for Wales 1999). An interviewee in England described the position that there was graduate level entry to nursing in Scotland, Wales and Northern Ireland but not yet in England as '*ridiculous*' (ENG11), whilst another interviewee in England '*hoped*' that the experience of Wales would help to drive the change to all

graduate entry to nurse training in England (ENG01). The degree level training in the three devolved countries will result in nurses with a higher level academic qualification upon registration in Scotland, Wales and Northern Ireland than those qualifying in England.

A further example of divergence noted earlier in the thesis was the different new nursing roles that were introduced in different UK countries, such as the development of the Modern Matron role in England. The Modern Matron is a more senior role than a Sister / Charge Nurse which was introduced to improve the quality of clinical care but this role was not adopted outside England. One interviewee in Scotland cited that the reason Scotland had not introduced the Modern Matron role was that '*we look to the future and not the past for our solutions*' (SC04), choosing instead to focus on reviewing the Sister / Charge Nurse role (Scottish Government 2008).

An interviewee from Wales recounted that the introduction of the Modern Matron was '*another announcement from 10 Downing Street before we actually got access to it . . . I don't want Hattie Jacques running around the ward, what I want is clinical leadership*' (WAL01). Wales adopted a similar approach to Scotland which included national funding to develop the Ward Sister / Charge Nurse role (Welsh Assembly Government 2008a). These examples highlight that each country was developing different approaches to strengthening clinical nursing leadership with the NHS.

However, one interviewee suggested that despite these variations in policy contexts, actual nursing practice across the UK was not significantly different (SC03). Another interviewee, from England, questioned the extent of the actual difference in healthcare policy, reporting that political rhetoric had resulted in '*difference for difference sake*' (ENG06). This view was consistent with the findings of the Nuffield Institute's longitudinal study into *Devolution and Health* which asked 'are the key policy differences anything

more than a superficial gloss on the same underlying set of activities . . . ?' (Jervis 2008, p.116).

In summary a small number of interviewees reported that policy divergence had impacted upon nursing through the emergence of different new nursing roles across the four countries and different approaches to pre-registration nurse training between the devolved countries and England. Three interviewees expressed the view that this policy divergence was detrimental to the profession particularly by restricting mobility of nurses or limiting the sharing of good practice between countries, whilst two interviewees reported that in their view not much had changed as a result of devolution. 19 interviewees did not raise the impact of policy divergence on nursing during the interviews.

6.2.3.3 Sharing and Adopting Best Practice

This section considers the views of interviewees on the opportunities and barriers to sharing and adopting good practice in relation to nursing policy across the UK, after devolution.

Five interviewees suggested that it would be beneficial to reflect on each country's experiences of devolution and learn from the best practice implemented across the UK (ENG03, ENG04, ENG07, ENG11, SC01). Four of the five interviewees were from England and one of these interviewees suggested that the good practice from the devolved administrations of Scotland, Wales and Northern Ireland needed to be '*pointed in the direction of England*' (ENG11) and disseminated more widely.

A model of collaboration in place in the UK at the time of the interviews was where one country assumes the lead role for a specific piece of work on behalf of the other countries, sharing its findings on completion. An example of this was cited as being the work NHSScotland carried out to develop a *Framework for Advanced Nursing Practice* (ENG05, WAL05). Scotland led

this work on behalf of UK colleagues, as part of the *Modernising Nursing Careers* policy initiative (Department of Health, Scottish Executive; Welsh Assembly Government and Department of Health, Social Services and Public Safety 2006), which was endorsed by the four country Chief Nursing Officers. Despite this four country collaboration and agreement that each country would lead on different workstreams, there was evidence that this agreement was not adhered to as further work was carried out within Wales culminating in the publication of the *Post Registration Career Framework for Nurses in Wales* (Welsh Assembly Government 2009). Similarly in England a group was established to develop guidance on *Advanced Level Nursing* (Department of Health 2010a); although this did acknowledge that the resultant position statement was informed by the original work undertaken in Scotland (NHSScotland 2008). The Scottish *Framework for Advanced Nursing Practice*³³ has subsequently been updated to include endorsements from the other three UK countries; however it is not clear how widely the toolkit has been used outwith NHSScotland.

The approach taken could be interpreted as each country developing its own solutions in line with the flexibilities available through devolution. Some interviewees expressed the viewpoint that the desire for difference across the four countries would lead to a '*richness*' and promote innovation (ENG01). An interviewee from Scotland reported that:

'policy will be different and that's quite right that it will be different because it has got to address those needs but what I am seeing is that actually we are starting to learn from policy across the four countries' (SC03).

This opportunity for increased policy learning created through devolution was also a finding of a study by the Institute of Public Policy Research (2008). Similarly the Nuffield Trust research on *Devolution and Health* highlighted that devolution provided an ideal opportunity for the four UK countries 'to observe and, where appropriate, mirror or adapt good practice to suit the needs of their own populations' (Jervis 2008, p.8). The example provided in

³³ This is also referred to as the Scottish Advanced Nursing Practice Toolkit.

relation to Advanced Nursing Practice indicated that this mirroring of good practice did not always occur as each country developed its own unique solution despite being 'signed up' to working collaboratively.

Two interviewees described examples of reluctance to adopt good practice in relation to nursing workforce policy from across the UK. The example of the pilot of the new model of Community Health Nurse in Scotland was cited by one interviewee in England as being a good initiative but was unlikely to be adopted in England, as it did not originate there (ENG11). Another interviewee from England who supported learning from good practice was dubious about the likelihood of this occurring as each country '*jealously guards their autonomy and independence*', acknowledging that getting NHS organisations to learn from each other was an uphill struggle as there was a strong desire to want to '*put their own badge on things*' (ENG07).

The tendency towards protectionism and reluctance to adopt initiatives and innovations from elsewhere is a wider trait of NHS organisations (Greenhalgh et al. 2004; Barlow, Burn and Lockhart 2008; Department of Health 2011). Furthermore there is frequently a reluctance of one NHS organisation to implement an initiative developed by another organisation, whilst within organisations there is often a failure to adopt good practice initiated in another ward or department. Barriers to adoption and spread of innovation within the NHS have been reported to include:

- inadequate sharing of information
- the size and complexity of the NHS
- lack of skills and expertise
- resistance to change and scepticism
- individual motivations

(Greenhalgh et al 2004; Gollop et al 2004; Williams, de Silva and Ham 2010).

Organisations including the NHS Institute for Innovation and Improvement, its predecessor the Modernisation Agency (MA) in England and the Centre for Change and Innovation (CCI)³⁴ in Scotland were established specifically to support the sharing of good practice and encourage adoption and spread of initiatives, generally within the country served rather than on a UK-wide basis.

Another post devolution issue was the continuation of various four country networks and organisations which now had to develop a balanced and broader understanding across four policy domains. Greer and Trench described the confused accountability and delicate legitimacy of UK-wide organisations when working in the devolved systems (2008, p. 35).

Two interviewees noted that there was a role for UK level national networks and organisations, such as the Council of Deans and NHS Employers (ENGx2³⁵) but in order to function in this UK-wide role there was a need for such organisations to develop an understanding of the commonalities and differences across the devolved administrations and guard against the tendency for agendas to be '*England centric*' (ENG11, WAL05), as this could prohibit engagement. An example raised by an interviewee from Northern Ireland was the guidance on setting appropriate ward staffing levels published by the Royal College of Nursing (2006), which was viewed as being tailored to the needs of England rather than the devolved countries, as it recommended a minimum ratio of 65% Registered Nurses in establishments which was considerably lower than the 77% Registered Nurses in the nursing workforce in Northern Ireland at the time of the interviews in 2008 (NI06).

In summary, although some interviewees acknowledged the good practice and innovation created through devolution, others reported that in reality there was a reluctance to adopt initiatives from the other countries preferring

³⁴ CCI ceased to exist prior to the interviews being undertaken.

³⁵ Interviewee identifiers have not been used to protect anonymity

instead to develop solutions within each country. This reluctance to adopt good practice from other countries of the UK was in line with the inherent culture across the NHS.

6.2.4 Nursing Leadership in Relation to Nursing Workforce Policy and Planning in the Four Countries

6.2.4.1 *The Role of Chief Nursing Officers*

During the interviews the researcher explored the impact that devolution had on nursing leadership in relation to the nursing workforce within the four countries and the dynamics of the working relationships between the four Chief Nursing Officers since devolution. The focus of this line of questioning was on nursing leadership specifically in relation to nursing workforce policy and planning. Two interviewees cited strong nursing leadership as being essential in the devolved administrations, with the Chief Nursing Officers being seen as key to '*holding things together*' (WAL03) and minimising divergence in nursing policy that could limit the mobility of nurses across the four countries of the UK (ENG01, WAL03). One interviewee in England identified a '*real problem*' between the four country Chief Nursing Officers whereby '*personal tensions . . . sometimes become an obstacle in terms of adoption*' of policies (ENG01).

Two interviewees in Wales reported a weakness in Wales relative to England, as they felt there was an absence of professional leadership and that the strongest leadership was being driven across the border from England (WAL05, WAL06). The most likely reason for this was the smaller size of Wales and its close proximity to England. Another interviewee from Wales highlighted the perception that England still tried to set the agenda and dominate the debate, although the proposals did not necessarily meet the specific requirements of the devolved administrations, describing the situation that sometimes it felt like being on '*the backfoot*' (WAL02). There are at least two possible explanations for this. One is a reflection of the perceived weaker professional leadership in Wales as reported by two

interviewees and the other is the desire for England to dominate health and nursing policy decisions across the UK. This latter point was reported in the literature review on devolution, where a lack of understanding of the differences between reserved and devolved powers by some policy makers in England was highlighted.

An interviewee noted that it was becoming increasingly more difficult for the four Chief Nursing Officers to agree on UK-wide professional nursing matters as they were being driven by the political and policy agendas from their respective countries (ENG11). Following devolution the Chief Nursing Officers in each of the four countries have a responsibility first and foremost to the Government of that country for the successful implementation of the relevant nursing and healthcare policies.

6.2.4.2 Modernising Nursing Careers

The development and implementation of the policy on *Modernising Nursing Careers* (Department of Health; Scottish Executive; Welsh Assembly Government and Department of Health, Social Services and Public Safety 2006) is a case study and opportunity to examine collaboration in practice across the four UK countries. *Modernising Nursing Careers* was the only example of a UK-wide nursing policy collaboration during the period under review. It was launched in 2006 as a four country initiative aimed at shaping the future direction of career paths for Registered Nurses across the UK; however work to develop this policy was in progress for some time prior to its publication in 2006.

As noted earlier in this thesis, *Modernising Nursing Careers* was established under the direction of the four Chief Nursing Officers, with each country taking the lead on a specific workstream. Although this was presented as a four country initiative, feedback from five interviewees indicated that in reality it was being driven by England as it was originally presented as an England only policy (ENG01, ENG11, WAL01, WAL02, NI06) and specific responses

included: '*it came out originally as an English only initiative and then there was a backlash I think from three CNOs*' (WAL01). It was a '*solo run by England to begin with and now the rest of us have had to catch up a bit*' (NI06) and '*it is a farce, a complete farce*' (ENG11). The end result was that *Modernising Nursing Careers* was presented as a UK-wide policy, however it was initially developed by England and this was followed by a disordered period during which the other three countries became involved. The reasons why this four country policy collaboration was of limited success will now be examined in more detail.

The group established to lead *Modernising Nursing Careers*, chaired by the Chief Nursing Officer in England, was described as being 'a UK-wide group of nursing leaders' (Department of Health et al. 2006, p.3). Although the group consisted of 25 members, it only included one representative from each of the three devolved administrations of Scotland, Wales and Northern Ireland. This was taken by some to be indicative of tokenism by England as opposed to a genuine commitment to four country collaboration. Furthermore 10 of the 25 members were employed within the Department of Health in England. This dominance of representation from England was noted by interviewees who indicated that the *Modernising Nursing Careers* initiative was principally being driven by England.

As part of *Modernising Nursing Careers* a consultation was held on the *Framework for Post-Registration Nursing Careers* (Department of Health 2007b). Six interviewees expressed disquiet that this consultation applied only to England (ENG11, WAL02, WAL03, WAL05, NI02, NI06) whilst two of these interviewees specifically described the fact this consultation applied only to England as '*nonsense*' (WAL05, NI02). There are two interpretations of this process: that England was attempting to control the policy direction, disregarding the viewpoints of Scotland, Wales and Northern Ireland, or that England, as the largest UK country, had grown used to leading the policy agenda and had not fully understood the implications of working on nursing

policies within the context of devolution. Based on the interviewees' narratives the former appears more likely, as several reported that England was driving this policy change with little regard for the other three countries, despite the public endorsements that this was a four country collaboration.

It was likely that England undertook the consultation to inform the future direction of post-registration nursing careers within England and if this was to have been a four country approach then all countries would have had to agree to participate which would have delayed the process. The post-registration consultation in England was carried out prior to the Nursing and Midwifery Council's consultation on the future of pre-registration nursing careers in 2008, however clarity on the future of pre-registration nursing was required before any informed decisions could be made in relation to post-registration nursing careers. Additionally this consultation on pre-registration nurse education (Nursing and Midwifery Council 2008b) was reported by two interviewees as not meeting the needs of all the four countries (ENG11, SC03).

If their views are correct this suggests policy disconnect between the Department of Health (England), the Nursing and Midwifery Council and the health departments of the other three countries of the UK. As one interviewee commented:

' . . . it is increasingly difficult for the Chief Nursing Officers to actually agree because they are being driven by specific country agendas so that's a big issue. I think the Regulatory Body is also in an interesting space in that it has a national remit in terms of regulation so they are trying to hold a line for pre-registration which isn't necessarily meeting the needs of the constituent parts of the UK. So I think there is an increasing tension between what the countries are saying, what the CNOs are saying, the line that statutory bodies are taking for pre-registration and where you are seeing some fractures, some change is at the post-registration end because it is much easier in effect for the countries to do what they want to do because it doesn't reflect in the main on the statutory regulator's function' (ENG11).

This interviewee also asserted that *Modernising Nursing Careers* should be addressing the whole continuum of nursing careers and should be

considered on a four country basis rather than the disjointed approach being taken (ENG11), whilst another interviewee in Scotland described *Modernising Nursing Careers* as providing the opportunity for the four UK countries to debate and agree the future of nursing including what the profession aspires to and what it wants to 'let go' (SC01).

Across the time this thesis was being researched and written, it was noticeable that there was waning support from the Chief Nursing Officers for *Modernising Nursing Careers*. It was phased out in 2010 without any real outcomes on a four country basis.

The *Modernising Nursing Careers* case highlighted the challenges faced by the Chief Nursing Officers in relation to working on a collaborative four country basis. Feedback from interviewees identified the perceived reluctance of the Chief Nursing Officers to implement nursing policy work from other parts of the UK. In the four countries interviewees provided mixed views about the power and influencing ability of their respective Chief Nursing Officers.

The *Modernising Nursing Careers* case study illustrated a number of different tensions which were in place and which had implications for the future development of the nursing profession across the UK. In summary there were tensions between the Nursing and Midwifery Council, the UK orientated regulatory body and the four UK countries due to the increase in policy divergence between countries. This was challenging for the four UK Chief Nursing Officers who were focused on delivering the policies within their own country, whilst ensuring they worked within the confines of UK-wide regulatory framework and standards. In addition to this there were reports of continued concerns about England attempting to dominate the other countries.

6.2.5 The Shifting Power Bases of Individuals and Organisations in the Devolved Administrations

As identified in the literature review, changing and different patterns of power and influence were reported as a consequence of devolution, creating potential opportunities for the nursing profession to have an increased influence on policy development. During the fieldwork all interviewees were asked their views on the impact of devolution upon nursing and nine interviewees identified different patterns of power and influence.

Overall nine out of the 19 interviewees from Scotland, Wales and Northern Ireland reported the increased accessibility to government Ministers by a range of individuals including members of the public, activists, healthcare professionals and policy makers that had occurred because of devolution (SC02, SC07, WAL01, WAL05, NI01, NI03, NI04, NI05, NI06). This feedback was received in response to general questions during the interviews on the impact of devolution on nursing. The other ten interviewees from the devolved administrations did not raise the issue of increased accessibility to government Ministers and were not probed by the researcher on this issue. Consequently it is not possible to report the views of these ten interviewees.

The increased accessibility reported by some interviewees has the potential to be difficult for government Ministers in some situations, particularly when controversial decisions need to be taken such as the closure of services. In Northern Ireland, for example, Ministers were reported to be '*more aware of the effect of different measures on society*' and the fact that these decisions could impact upon the popularity of that Minister and cost votes (NI01, NI02). This message was reinforced by comments made during the interviews when it was claimed that the closure of a local service did not matter to a direct rule Minister, distanced in Westminster, as such decisions have less impact than on a local politician (NI01, NI02). The effect of this may be heightened due to

the fact that since devolution, politicians live and work within the one country, whereas prior to devolution the majority of their time was spent at Westminster in London with approximately one day per week allocated to their local constituency.

An example of Ministerial action in response to a local issue was the result of unannounced visits made in 2007 by the Minister for Health and Social Services to Accident and Emergency Departments in Wales. During these visits, nursing staff raised concerns that they were paid on different pay bandings for undertaking the same duties (WAL01). The Minister commissioned an Independent Review (Jenkins 2007) which highlighted that the implementation of *Agenda for Change* in NHS Wales 'lacked sufficient strategic direction at the all Wales level' (p.10). The recommendations from the review report included the proposal for a more centralised NHS Wales approach to future job evaluations and Agenda for Change appeals, along with actions to deal with pay protection and equity. The report was completed in December 2007, accepted by the Minister in February 2008 but it was not until April 2009 that the recommendations were finally agreed for implementation (Hart 2008; Hart 2009). The reason for this delay was that the impact of the recommendations 'including the cost and equality implications' needed to be considered in full by the Partnership Forum in Wales (Hart 2008, p.2). This was an example of a Minister taking direct action in response to concerns raised by a specific group of nursing staff but the recommendations of the report had broader implications for NHS staff in Wales beyond the group of Accident and Emergency nurses who raised the original concern.

The example described by this interviewee demonstrates the closeness between politicians and members of the nursing profession and the expectation that action will be taken by Ministers and politicians in response to issues raised.

Through this increased access to local politicians, professional nursing bodies and trade unions were reported to have a stronger voice (NI03, NI04, NI06), greater power and influence (SC01, SC05) or as being a '*force to be reckoned with politically in terms of political influencing for nursing policy*' (WAL01). One interviewee in England noted that devolution had also created greater freedom for some professional organisations and trade unions, as it enabled political pressures to be applied on behalf of nurses in more direct ways (ENG03).

One point that was noted was that professional organisations were essentially '*using*' political parties by submitting Parliamentary Questions to get debates started; for example it was noted that such action had led to a review of workforce planning being commissioned in Wales (WAL01). Although Parliamentary Questions were used in the Westminster Parliament prior to devolution, Parliamentary Questions had a more localised focus following devolution.

Another example cited was that the first Welsh Assembly Government debate on nursing involved nurses from the NHS facing Ministers directly and presenting evidence, with support from their professional association or trade union (WAL01). This session was scheduled to last one hour but lasted for three due to the interest from Ministers in hearing the personal experiences of nurses involved in direct patient care (WAL01). Prior to devolution there would have been fewer opportunities for clinical nurses to be directly exposed to such high level political debates on health policy. The increased power of professional organisations after devolution was also cited by an interviewee from Northern Ireland who reported that professional organisations were often the driving force behind the questions to the Members of the Legislative Assembly (MLAs) and that a whole industry has been created to respond to the questions posed to the 108 MLAs in Northern Ireland (NI05).

It was observed by one interviewee in Northern Ireland that some members of trade unions or professional organisations have discovered that his or her MLA is '*a very good shop steward*' (NI05) and in order to capitalise on this some organisations have developed courses for nurses to enhance their political campaigning skills enabling members to work more effectively with local politicians (NI05). This interviewee did however recognise that there was a real risk that professional organisations and trade unions were no longer able to control the content of the Parliamentary Questions or the political campaigning (NI05), as some members were bypassing the traditional professional organisation / trade union route and posing questions directly to MLAs. A similar viewpoint was expressed by an interviewee from Scotland who stated that there was a need for each country to remain focused on its key priorities as there was the potential for these to be distorted through such political campaigning (SC07), whereby individual members escalate issues which are more aligned with personal interests rather than wider professional priorities.

The findings from the interviews illustrate that professional organisations and trade unions have adapted their new ways of working to maximise their influencing ability in the devolved administrations. Although Parliamentary Questions and local lobbying were not new methods of influence, there were new forums in which to exercise these in the devolved administrations, which were closer to nurses' working places.

As part of the background research undertaken for this thesis the career paths of senior staff in professional organisations and trade unions were reviewed. The reason for this was to assist the researcher in identifying patterns in responses between different interviewees. Over the period of this study, there were incidences of individuals in each of the three devolved administrations who either worked for or were previously employed by the Royal College of Nursing also holding senior posts within government health departments in their respective countries and examples included:

- the Chief Nurse in Northern Ireland was previously the Director of the Royal College of Nursing in Northern Ireland
- the Director of the Royal College of Nursing in Wales previously held the post of Nursing Officer in Wales
- the Director of the Royal College of Nursing in Scotland was previously employed as the Deputy Chief Nurse in Scotland.

All of these examples involved individuals changing roles within the same country rather than movement between countries. More specifically the movement identified was between the respective government's health department and the Royal College of Nursing or vice versa. These examples highlight the greater potential for closer working between government health departments and the leaders of professional organisations in the devolved administrations. This is based on the power and influence of individuals whereby the professional and personal networks, detailed understanding of organisational cultures and policy making processes developed in one role have obvious benefits in the other role. Alternatively this could be perceived as a conflict of interest as these individuals have an in-depth knowledge of how both organisations work with the potential for 'split loyalties' or for compromises to be made in order to maintain professional relationships and protect possible future career options.

Furthermore the small number of experienced senior nurses with the skills suited to these types of roles in the devolved administrations demonstrates the limited talent pool available and the need for a greater focus on succession planning for these senior nursing roles. The movement of staff between the government health department and professional organisations or trade unions was not replicated in England, where there are more options for alternative employment. This is particularly due to the fact that the headquarters of the majority of national (UK) organisations are based in England and the larger number of NHS organisations in England. Another aspect of this shortage of experienced senior nurses was illustrated by an

interviewee from Scotland who estimated that, at the time of the interviews in 2008, 50% of the Directors of Nursing in Scotland were from England (SC03).

6.2.6 Summary of Key Points

This section focused on reviewing interviewees' responses to questions on devolution and its impact on nursing workforce policy and planning across the four countries of the UK. A number of different perspectives on devolution were raised during the interviews and the key points are summarised below.

Overall a range of different views were expressed by interviewees in relation to the impact of devolution upon nursing. 14 interviewees reported that devolution had resulted in increased flexibility and responsiveness to local priorities within healthcare generally; 13 interviewees were explicitly positive about the impact of devolution upon nursing, whilst 5 interviewees described devolution's negative impact. Just under half of interviewees (13/30) gave no view on this matter which may indicate that there was not strong support for devolution having had a positive impact upon nursing.

In line with the findings of wider studies on devolution and health, interviewees reported health policy divergence between the four UK countries. However this thesis also identified divergence in nursing policy across the UK, including the implementation of different new nursing roles, a range of approaches to clinical leadership and disparity between the devolved administrations and England in relation to graduate entry programmes for pre-registration nurse education. Some interviewees highlighted the positive aspects of this policy divergence such as encouraging innovation, whilst others raised concern about its potential impact on restricting the future mobility of nurses across the UK, although at the time of the interviews there was no evidence that this had occurred.

Devolution was recognised as creating opportunities for innovation in nursing workforce policy and planning but there was a reported reluctance to share good practice and learn from experiences between countries. This was demonstrated through the case study on *Modernising Nursing Careers*, which despite being a UK wide initiative endorsed by the four Chief Nursing Officers, there was no evidence of the work undertaken in one country being adopted in the other countries.

Different patterns of power and influence emerged as a consequence of devolution. The Chief Nursing Officers in each of the four countries were responsible principally to their respective Governments making it more challenging for Chief Nursing Officers to reach agreement on UK-wide professional nursing issues. Linked to this there were other influences including England's desire to lead on nursing policy issues, whilst some national (UK level) organisations had not fully understood how to function within the devolved administrations, resulting in an England centric focus. Overall this resulted in tensions between the different policy perspectives of the four UK countries, the four Chief Nursing Officers who were trying to balance their primary responsibilities within their individual countries, whilst holding the line on nursing issues at a UK level and the tension with the Nursing and Midwifery Council, the UK regulator for nursing.

Just under half of the interviewees from the devolved administrations (9/19) reported that devolution had resulted in increased accessibility to government Ministers and politicians by members of the public, including nurses. Ministers were reported to be more responsive to local healthcare issues than was the case prior to devolution and this was principally due to the closer proximity of these politicians to local constituents and health services. Professional organisations and trade unions were acknowledged to have adapted their ways of working to exploit the new opportunities to influence which had been created through devolution.

The movement of senior nursing staff between government health departments and the Royal College of Nursing in the devolved administrations was highlighted. This illustrated issues in relation to a limited talent pool in the devolved countries and the potential for some working relationships to be too close for open government.

Overall a range of issues related to devolution and its impact upon nursing workforce policy and planning were identified in this section of the chapter on Analysis of Interview Data and Reporting of Findings. These issues will be considered further in chapter seven, which explores the relationship and connections between the findings on devolution with the other findings highlighted later in this chapter.

6.3 Key Health Policies

6.3.1 Overview of Key Health Policies

This section will report the findings from the 30 interviews on the key health policies cited as being important for nursing in each of the four countries over the period under review. The focus of reporting is the main policy theme identified across the UK but issues of significance relating to policies within individual countries are highlighted too.

The analysis of the health policies (chapter two) informed the literature review and development of the interview schedule. One of the main points from the policy analysis was that between the start of the study period in 1997 and the introduction of devolution in 1999, there was consistency in relation to health policies due to the influence of the Westminster Parliament. This included policies aimed at improving access to care; better quality of care; enhanced partnership working with patients; the provision of more services in primary care and the rationalisation of acute services. Following devolution there was evidence of divergence in health policy emerging between the four countries resulting in different policy priorities which included England's focus on performance management, competition and

quality of care; Scotland's attention was on increased collaboration with patients and professionals whilst health policy in Wales was targeted at reducing health inequalities and delivering improvements in primary care services. In Northern Ireland policy divergence was less pronounced, predominantly due to the intermittent nature of devolution during the period under review. In addition to these different policy priorities following devolution, there was a strong policy focus on shifting care from acute hospitals into community settings across all four countries.

Each interviewee was asked to identify the three health policies which had impacted most upon nursing over the period 1997 to 2008. The reason for asking for three policies to be identified was that this would result in a dataset of 90 responses across the four countries, providing a reasonable number of policies for the researcher to review and then identify the key themes. Asking interviewees to select three policies from across an 11 year period also focused their attention on the policies which, in their view, were the priorities and which had the most influence on nursing within each country. The responses enabled the researcher to identify not only each interviewee's assessment of the most significant policies but also the extent of similarity or difference of views across the four UK countries.

The aim was to make comparisons between the responses at interview and the main policy themes identified in the policy analysis and literature review, reporting on areas of similarity and variation. This information was sought to help address the research question:

- *What has been the impact of devolution on nursing workforce policy and planning across the four countries of the UK (1997-2009)?*³⁶

Each interviewee typically cited three policies, as requested, although the range was from one to six per interviewee resulting in a total of 106

³⁶ The interviews were undertaken in 2008 but following the interviews, during the write up of findings, relevant policies from 2009 were also considered as these policies would have been in development at the time of the interviews.

responses. The 106 responses included the identification of 33 separate policies by 46 interviewees, as some policies were reported by more than one interviewee. Additionally some interviewees reported policies whilst others reported policy drivers or a combination of both. In this thesis the term policy drivers has been used to describe the responses which were not actual policies but factors which may have influenced policy development for example a '*funding crisis*' (WAL04), '*shortages of nurses*' (NI05); or factors which have resulted from the implementation of policies for example '*new roles*' (ENG08) or '*structural reforms and trust mergers*' (WAL06).

In assessing the broad range of responses from interviewees it became evident that a systematic approach was needed to summarise the wide range of responses and enable the information to be presented in a coherent format. In order to achieve this, the researcher listed details of the key policies on an excel spreadsheet which has been replicated for information in Appendix XV.

The pattern of responses is considered in the sections below, as well as an assessment of why some of the policies which emerged from the literature review and policy analysis were not identified by the interviewees as being important. In line with realist review methodology, consideration will be given to the reasons why policies were considered to be important or not.

6.3.2 Reported Key Health Policies and Policy Drivers

Across the four countries of the UK the two policy responses most commonly reported by interviewees to have impacted upon nursing over the period 1997-2008 were policy drivers rather than specific policies. These two policy drivers were:

- shift in care from acute hospitals into community settings
- the changing role of nurses, including the impact of reductions in junior doctor's working hours.

It is of significance that although interviewees were asked to identify health policies the most common responses were in fact examples of policy drivers. This finding indicated that individual policies were not reported as having had any clear impact upon nursing across the UK. The two most commonly reported policy drivers will now be considered in greater detail.

6.3.2.1 Shift in Care from the Acute Sector

Shift in care is a policy driver aimed at reducing activity in acute hospitals through a range of initiatives including the avoidance of admissions by early detection of health problems, shorter lengths of stay for patients due to increased support closer to home and more services being provided in GP surgeries or community hospitals. The shift in care from acute hospitals to primary or community care settings was highlighted by 15 of the 30 interviewees as having a significant impact upon nursing (ENG02, ENG04, ENG06, ENG11, SC02, SC03, SC04, WAL02, WAL03, WAL04, WAL05, WAL06, NI01, NI02, NI06). This included responses which cited policies where this shift in care was a key component of the policy objectives, for example *Delivering for Health* detailed the reduced 'reliance on episodic, acute care in hospitals' and a focus 'towards more continuous care in the community' (Scottish Executive Health Department 2005b, p.vi). Similarly *Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century, a 10 year Strategy* (Welsh Assembly Government 2005a) included proposals to provide more care closer to home in local neighbourhoods.

As identified in the policy analysis (chapter two), shift in care from acute to community settings has been a key policy drive for a number of years. Progress with its implementation reportedly has been extremely slow or, in some areas, non-existent (Craig et al. 2002; Welsh Assembly Government 2003a; NHS Institute for Innovation and University of Birmingham Health Services Management Centre 2006; Harvey and McMahon 2008; Healthcare Commission and Audit Commission 2008; Nursing Times 2008; Audit

Commission 2009; Crump 2009, Scottish Government et al. 2010). During the fieldwork, two interviewees commented specifically upon the failure to deliver this shift in care (ENG03, WAL04). In England an interviewee attributed this to the *Payments by Results* policy which financially rewards acute trusts for in-patient activity (ENG03) (see Smith 2007 for similar argument).

One reason that this policy driver was reported most frequently may be that it has been a policy focus in each country across recent years. Another explanation is that interviewees may have been involved directly with its implementation, in their current roles and therefore it was at the forefront of their thinking at the time of the interviews. Although the shift in care was the policy most commonly identified by interviewees it had not been successfully implemented, with the exception of localised areas of good practice where new community services had been established (Harno et al. 2002; NHS Institute for Innovation and University of Birmingham Health Services Management Centre 2006 and 2007). The failure to implement the shift in care was reported by two interviewees and it was also outlined in the reports and references cited in the paragraph above.

6.3.2.2 Changes to Nursing Roles

The second most commonly reported policy driver was the changing role of nurses, which was reported by 10 interviewees (ENG02, ENG04, ENG05, ENG07, ENG08, ENG09, ENG11, SC05, NI01, NI02).

Interviewees provided different perspectives on the reasons behind the emergence of new roles for nurses. The *European Working Time Directive* (Council Directive 1993) and the associated funding (ENG05, ENG11) were identified as factors driving the development of new or advanced nursing roles (ENG02, ENG08). Two interviewees reported the impact of health policies more generally on challenging professional boundaries (ENG04, ENG11) but provided no further clarification on this, whilst others noted there

were more nurses working in different ways particularly as a consequence of *the NHS Plan* in England (Department of Health 2000a), which enabled the introduction of a different type of nurse and created opportunities for the development of specialist and Consultant Nurse roles (ENG07, ENG09, ENG11).

During other lines of questioning, interviewees raised the impact of *Modernising Medical Careers* (Department of Health 2004b) (ENG06, SC02); the reduction in junior doctor's hours (ENG01, ENG05, SC05, NI02); the introduction of NHS 24 in Scotland (SC05) and GP out of hours arrangements (NI01), as having all resulted in nurses taking on work previously undertaken by medical staff. Another factor was non-medical prescribing which was raised by three interviewees (ENG02, ENG04, NI05).

In addition to the changing role of nurses another theme which was reported by six interviewees from England, was the high levels of growth in the nursing workforce (ENG01, ENG02, ENG06, ENG07, ENG09, ENG11), which was reflected through trends in the nursing workforce data presented in chapter five. The expansion of the workforce is not a policy as such but there was a policy target for nursing workforce growth in England stated in *the NHS Plan*. This expansion of the nursing workforce was a requirement for the successful implementation of other policies, for example if nurses take on new roles in support of other professions but continue to undertake traditional nursing work then more nurses need to be recruited and trained.

6.3.2.3 Policy Themes within Countries

The policy responses were also reviewed on an individual country basis to establish if there were particular themes within each of the four countries.

The main policy themes reported within England were changes to nurses' roles and the growth in the nursing workforce, which were identified by seven interviewees and six interviewees respectively. These responses have

already been covered in section 6.3.2.2 above, as the majority of interviewees reporting these policy drivers were from England.

In Scotland *Facing the Future* (Scottish Government 2007c; Scottish Executive Health Department 2009), an initiative to boost nursing recruitment and retention, was cited by two interviewees as being an important policy (SC01, SC06). This was described as having been a '*major turning point*' for nursing which had both Ministerial support and embodied partnership working with staff organisations (SC01). Another interviewee reported the Staff Governance (partnership working) arrangements introduced since devolution which were described as having created a dynamic industrial relations climate where the level of change was '*far quicker and deeper than there would have been in a non-partnership environment*' (SC04).

Overall there was a broad range of responses about key policies in Scotland, with a divergent range of policies identified by different interviewees and consequently no consistent themes could be established from these responses. A total of 17 policy initiatives were listed by the six interviewees and of these only one policy initiative (*Facing the Future*) was reported by more than one interviewee.

In Northern Ireland, five out of the six interviewees identified policy drivers which were linked to the nursing workforce including: new nursing roles (NI01, NI02), access routes into nurse training (NI04), nursing shortages (NI03, NI05) and nursing workforce planning (NI05). Two interviewees highlighted that there was an increasing number of policies aimed at improving the quality of patient care (NI03, NI04) whilst *Developing Better Services: Modernising Hospitals and Reforming Structures* (Department of Health, Social Services and Public Safety 2002a) outlined reforms for the future of acute hospitals in Northern Ireland, including hospital closures (NI06). Furthermore the Review of Public Administration in 2006 (Department of Health, Social Services and Public Safety 2006) led to a

radical reduction in the number of Acute and Social Care Integrated Trusts from 18 to five (NI02, NI06) which was reported to have impacted significantly upon '*nursing at senior levels*' (NI05).

In Wales four of the six interviewees identified *Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century, a 10 year Strategy* (Welsh Assembly Government 2005a) as being a key policy (WAL02, WAL03, WAL05, WAL06) and it was reported that this was '*steering everything that we will be doing*' in Wales (WAL02). *Designed for Life* was considered by one interviewee to have changed the way policies were being written as '*they were much harder, crisper . . . with a greater level of expectation than had previously been the case*' (WAL03). Overall responses from the Welsh interviewees were the most consistent; although an alternative interpretation could be that they said the same things as they had regular dialogue together through close working arrangements. This regular dialogue could also be a feature of the other devolved countries, Scotland and Northern Ireland; however there was less consistency in the policy responses reported by interviewees from these countries.

On reviewing the health policies identified within each of the four countries the responses in each country were generally quite broad, with the exception of Wales where there was a high level of similarity in responses. The broad range of policies and policy drivers reported by interviewees was attributable to the large volume of policies published over the period under review, particularly since devolution, as evidenced in the policy logs (chapter two and appendices IV-VII) and the lack of agreement on which were the most significant policies and policy drivers. In addition to the policies published, there were also a high number of policy consultations as highlighted in a UK-wide Royal College of Nursing report, which cited the receipt of 'a staggering

138 consultations³⁷ all of which required responses over the period January 2006 to April 2007 (RCN 2007b, p.12).

These different policies have different implications for the nursing workforce including the development of new nursing roles. One of the challenges resulting from the wide range of policy initiatives reported was the need to ensure the timely supply of the nursing workforce with the required skills and expertise to successfully implement these policies. An example of this was the policy target for nursing workforce growth identified in *the NHS Plan* in England as highlighted in section 6.3.2.2. The broad range of policies and policy drivers in each of the four countries have implications for the numbers of places commissioned on pre-registration nurse training programmes; the composition of nursing establishments including skill mix, and the priorities for post-registration nurse education within each country. Any repercussions for the content of pre-registration nurse training would require consultation with the Nursing and Midwifery Council which sets the standards for pre-registration nursing education on a UK-wide basis.

6.3.3 Policies Which Were Not Identified as Priorities

Another finding of this study was that some policies were either not referred to or identified by only a few interviewees.

No interviewees identified the national Human Resource Strategy of the country they were working in as being one of the most important policies to have impacted upon nursing (Department of Health 1998; Scottish Office 1998b; National Assembly for Wales 2000b; Department of Health, Social Service and Public Safety 2002b). The most likely explanation why these policies were not cited was the time which had lapsed since development of the policies and the interviews, as all the Human Resource Strategies were published over the period 1998-2002 several years before the interviews in 2008. Other reasons for these Human Resource Strategies not being

³⁷ Although this was a UK-wide report it was not clear if the 138 consultations applied across the UK or to England.

reported as important could include them not having been fully implemented within each country or not having been deemed relevant to nursing. Additionally very few of the interviewees had direct involvement in the development or implementation of the Human Resource Strategies in their respective country.

The policies which were reported as being important by only a small number of interviewees included:

- the country level Nursing Strategies
- Modernising Nursing Careers
- Agenda for Change.

The Nursing Strategies were published over the period 1998-2002 (Department of Health and Social Services 1998c; Department of Health 1999a; National Assembly for Wales 1999; Scottish Executive Health Department 2001a) although, as noted earlier, Scotland also published a refreshed Nursing Strategy in 2006 (Scottish Executive Health Department 2006b). Despite the time which had elapsed since the Nursing Strategies had been published, each country's Nursing Strategy was still technically a live policy at the time of the interviews but in reality these policies were not actively in use. Only four of the 30 interviewees made reference to any of the Nursing Strategies as being a priority (1xSC0, 1xENG, 2xWAL)³⁸ and none of the three Chief Nursing Officers interviewed cited their country's Nursing Strategy as being a key policy. It is a notable finding that none of the Chief Nursing Officers interviewed identified their own Nursing Strategy as being important, even although two of the three Chief Nursing Officers interviewed were in post when their country's Nursing Strategy was developed and published. If these Nursing Strategies were not valued by the Chief Nursing Officers then they were unlikely to have had a significant impact upon the nursing profession in each country and therefore the low rates of reporting of these policies from other interviewees was understandable.

³⁸ Details of respondents have been restricted to protect anonymity.

The four country policy initiative *Modernising Nursing Careers* (Department of Health; Scottish Executive; Welsh Assembly Government and Department of Health, Social Services and Public Safety 2006), as discussed earlier in section 6.2.4.2, was cited by only three interviewees as being a priority (ENG06, ENG10, SC06). One interviewee expressed the view that this policy:

'is more philosophical than practical, I think in terms of workforce application or more qualitative than quantitative but that will have a bearing. . .' (ENG10).

Two of the three interviewees who reported *Modernising Nursing Careers* were from England which is in line with findings reported earlier in this chapter, that this policy was principally being led by England.

Agenda for Change (Department of Health 1999b) the major overhaul of NHS pay, terms and conditions which was implemented between 2004 and 2006, was reported by only five interviewees (ENG03, ENG04, ENG07, ENG08, NI05) as being a key policy. The small number of interviewees who cited *Agenda for Change* could be related to the fact that only four of the 30 interviewees in this study held roles which had direct responsibility for pay determination, whilst a further eight held roles which included indirect influencing on pay and conditions. Two of the five interviewees who cited *Agenda for Change* had influence over pay determination, one directly and one indirectly. Senior nurses in policy positions, for example Chief Nursing Officers, do not take part in pay determination decisions as this is the responsibility of the Directors of Workforce in each country and this could have been a factor in the low number of interviewees who reported this policy. Interviewees' direct or indirect responsibility for pay determination was not a key factor influencing those who cited *Agenda for Change* as being an important policy.

Although the implementation of *Agenda for Change* had huge cost implications and incurred significant upheaval across all four countries of the

UK, four of the five interviewees who cited *Agenda for Change* as being a key policy to have impacted upon nursing were from England.

6.3.4 Summary of Key Points

The two policy drivers which were reported by interviewees as having impacted most upon nursing over the period 1997-2008 were:

- the shift in care from acute hospital settings into the community, which was identified by 15 out of 30 interviewees
- the changing role of nurses as reported by 10 out of 30 interviewees.

In each of the four countries a number of different policies and policy drivers were identified as being important. In England seven out of 11 interviewees cited the changing role of nurses, whilst six out of 11 highlighted the significant growth in the nursing workforce as being important policies to have impacted upon nursing. The most commonly reported policy in Wales was *Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century, a 10 year Strategy*. In Scotland and Northern Ireland a more diverse range of policies and policy drivers were reported.

Several key policies identified in the policy analysis reported in chapter two were not identified by interviewees. There had been an expectation by the researcher that these policies would feature more prominently in responses from interviewees. The Human Resource Strategies from each of the four countries were not reported by any interviewee as having been a key policy that impacted upon nursing; *Modernising Nursing Careers* was only reported by three interviewees; the Nursing Strategies by four interviewees and *Agenda for Change* by five interviewees.

Although interviewees were asked to reflect on the period 1997-2008, responses may have been more aligned to policies which had been developed or implemented around the time of the interviews in 2008. Views on issues earlier in the period were expressed with hindsight, however when

reflecting on the feedback from interviewees this does not appear to have been a significant effect, as a number of the policies identified were from different timeframes across the eleven year period under review.

The wide range of policies that were identified, both across the UK and within individual countries, was a finding of this research. This finding was within the context of the large number of policies identified in the policy analysis (chapter two) and the health policy divergence following devolution as described in the literature review (chapter three). Another key finding was that policy drivers were more often cited than individual policies.

6.4 Nursing Workforce Planning

6.4.1 Overview of Nursing Workforce Planning

The earlier sections of this chapter, covering devolution and key health policies, focus on the first research question:

- *What has been the impact of devolution on nursing workforce policy and planning across the four countries of the UK (1997-2009)?*

This section on nursing workforce planning and the subsequent sections on recruitment and retention are focused on addressing both the research question above and the second research question:

- *How and why have the approaches to nursing workforce policy and planning changed across the four countries of the UK (1997-2009)?*

In this section the key findings of the interviews in relation to nursing workforce planning will be discussed. This includes the reported views on how this function has changed in the four countries over time and with the introduction of devolution. The questioning during the semi-structured interviews was informed by the literature review which identified a number of themes in relation to NHS workforce planning. The key themes mainly as reported by the House of Commons Health Committees in England and equivalent committees in Scotland and Wales were:

- the lack of clarity over responsibilities for workforce planning
- deficits in workforce planning capacity and capability
- central ('top down') versus local ('bottom up') approaches to workforce planning
- the lack of integration between workforce, service and financial planning
- the identified need for better integration between workforce planning for medical and non-medical professions.

Additionally the potential for undertaking nursing workforce planning on a UK-wide basis was discussed with interviewees. This was included to establish if there had been a change in view in relation to four country collaboration following devolution, particularly in relation to the patterns of '*boom and bust*' in nursing workforce supply.

Although the themes identified from the literature review related to workforce planning across the broader NHS workforce, during the key informant interviews the questions focused specifically on nursing workforce policy and planning.

This section of the chapter will follow the same sequence as the key issues detailed above whereby the findings of each of the lines of questioning across the four countries is presented, followed by a discussion of any significant issues that have emerged from individual countries.

6.4.2 Responsibility for Ensuring the Nursing Workforce is Considered When New Health Policies are Developed

In terms of trying to establish the views of interviewees on who held responsibility for nursing workforce planning, the focus was on '*who holds responsibility for ensuring that the nursing workforce implications are taken into account when new health policies are being developed?*' This is a different line of questioning to that of identifying who has responsibility for the

technical aspects of nursing workforce planning. The reason for this particular focus was the researcher considered that asking interviewees who holds responsibility for NHS workforce planning was too broad a line of questioning, as responsibility for the technical aspects of workforce planning can be at a national (country), regional or local (organisational) level and interviewees could have different interpretations of what the workforce planning function involves.

The researcher chose to seek views on who holds responsibility for ensuring that the nursing workforce is considered when new health policies are developed, as this is a critical step in the nursing workforce planning process but one which has not been addressed in the UK literature on nursing workforce planning. If the impact of new health policies on the nursing workforce is not considered at an early stage, then there will be consequences when the policies are being implemented if the supply of nurses with the required skills and competencies is not readily available in the workforce to deliver the policy ambitions. Health policies may include changes to clinical practice and treatments which necessitate variations in the number of nurses required in particular settings, which also need to be planned for. The requirement to consider the workforce implications during health policy development was highlighted as an area for improvement in the House of Commons Health Committee report (2007a). Additionally the lack of clarity about the responsibility and accountability for workforce planning generally was highlighted in a number of reports (including House of Commons Health Committee 1999a, 1999b; House of Commons Health Committee 2007a, 2007b; Scottish Parliament Health Committee 2005; Imison, Buchan and Xavier 2009).

Professional nursing involvement in the policy development process increases the likelihood that, if the implications for the nursing workforce are deemed to be unrealistic then action can be taken at this stage to identify alternative workforce solutions. Gaining a greater insight into who holds

responsibility for ensuring the nursing workforce is considered during the development of healthcare policies also added an extra dimension to the information gleaned in relation to the health policies which had impacted most upon nursing as reported earlier in this chapter (section 6.3).

A wide range of answers was received to the question about who holds responsibility for ensuring that the nursing workforce is considered during the development of health policies. Some interviewees identified individuals in specific posts as having a lead responsibility, whilst others described this as being the joint responsibility between several post holders. Another viewpoint expressed by several interviewees was that this responsibility rested with Governments rather than individuals. The majority of interviewees who provided responses to this question cited that this was a shared responsibility between individuals in specific roles or departments within or across organisations (20/27).

Five interviewees, all from the devolved nations, identified the role of the respective government health departments in ensuring that the nursing workforce is considered when new policies were being developed (SC04, SC07, WAL02, WAL03, NI04), whilst two of these interviewees also identified this as a specific responsibility of Ministers (SC04, WAL02). Three interviewees (WAL03, WAL06, NI06) cited the responsibilities of the nursing directorate within the respective health departments but these were reported as being shared responsibilities with other government departments or wider stakeholders.

Five interviewees specifically identified the Chief Nursing Officers in their respective countries as having responsibility for ensuring the nursing workforce is considered during the development of new policies (1xENG, 1xSC, 1xWAL, 2xNI)³⁹ but only one of these was a Chief Nursing Officer. All of the five interviewees who cited the Chief Nursing Officers as having this

³⁹ Details of respondents have been restricted to protect anonymity.

responsibility indicated it was a shared responsibility with others including: the Director of Workforce from the relevant health department (1xSC, 1xNI); government Ministers (1xSC); the health department Management Board (1xWAL); a range of stakeholders (1xENG) and Staff Side Organisations (1xNI).

Five interviewees reported that Workforce Leads or Directors of Human Resources in government health departments were responsible for ensuring the nursing workforce was considered during the development of new policies (ENG07, WAL02, WAL05, 1xSC, 1xNI). Three interviewees reported that this responsibility was shared with others including: with government Ministers and the health department Management Board (WAL02) and, as noted above, the Chief Nursing Officer (1xSC, 1xNI).

At the time of the interviews the Chief Nursing Officer and Director of Workforce roles in Scotland were covered by one individual. This joint role was unique to Scotland and feedback from four interviewees highlighted the benefits for nursing (SC01, SC02, SC06, SC07), whilst another interviewee commented on the fact that there were no '*power struggles*' between the two roles (SC04).

One interviewee from Scotland described the need for a combined approach between:

'individuals centrally and the nursing leads within the Boards because again it is about it's all fine and well sitting in an ivory tower writing a policy but unless you are speaking with those who are actually going to implement the policy in practical terms . . .' (SC06).

Similar views were expressed by interviewees who identified the need to involve staff at all levels across a range of organisations including working groups and professional organisations / trade unions (ENG03, ENG05, SC01, WAL06, NI03, NI04). These examples highlighted interviewees' views on the importance of involving staff who understand the practical implications of the proposed policies on the nursing workforce.

Six interviewees specifically raised the lack of responsibility in relation to ensuring that the nursing workforce is considered when new health policies are being developed (ENG02, ENG04, ENG06, SC05, WAL01, WAL04).

This was illustrated by an interview who stated that:

'one of the significant criticisms we would have is that the answer to that [question] has been nobody. I think interestingly it has been a lack of two way conversation if that is not a contradiction in terms. In that I think that for quite a long time policy has been developed quite often without thinking about the workforce implications and workforce planning has been developed without thinking about the policy implications, actually. The two have gone fairly separately' (ENG06).

Another interviewee from England also cautioned that: *'one of the things about NHS or Department of Health policy development is it is often evidence light' (ENG07).*

Overall there was a range of different views regarding who has responsibility for ensuring the nursing workforce is considered when new health policies are being developed. Interviewees' responses illustrated that there was a lack of clarity or unanimity, in each of the four countries, about who actually held responsibility for ensuring that when policies are being developed the implications for the nursing workforce were considered. There was therefore scope for confusion both within individual countries and across the UK.

The majority of interviewees did not cite government health departments or Ministers as having responsibility for considering the nursing workforce during policy development. Consequently this could mean that policies are published without a full assessment of the implications on the nursing workforce being carried out. In the absence of this impact assessment by the relevant government health department; the nursing profession, including Chief Nursing Officers, Professional Organisations, NHS Directors of Nursing and nurse educators, may have to respond at short notice to support the implementation of particular policies. An example was provided by an interviewee in Scotland who described the development of a policy to

implement 'well men' clinics through an initiative known as 'Prevention 2010' (SC02). This interviewee acknowledged that *'it was a great policy and the type of policy you would like to implement straight away but the staff don't grow on trees . . .'* and consequently its implementation was delayed until the required workforce was available (SC02).

Although this section has focused on who holds responsibility for ensuring the nursing workforce is considered during the development of new policies, the researcher also examined if there was clarity regarding the responsibility of Directors of Nursing in relation to workforce planning at an organisational level. A survey of 200 expert stakeholders, including Executive or Non Executive Directors, in England identified low levels of reported responsibility for changes in 'workforce management'⁴⁰ amongst nurse leaders (Burdett Trust for Nursing 2006).

The researcher reviewed the role of Nurse Directors in relation to nursing workforce planning by examining four⁴¹ job descriptions for vacant Director of Nursing posts in England. Only one of the four posts reviewed included clear responsibilities for nursing workforce planning.

The impact of devolution on who held responsibility for ensuring that nursing is considered when new health policies are being developed did not come up specifically in the interview discussions. This was due to the focus of the question being on who held this responsibility at the time of the interviews in 2008. This was nine years following the introduction of devolution and interviewees did not provide details of changes in this responsibility following devolution.

⁴⁰ No definition of workforce management was provided by the Burdett Trust but reference was made to aspects of workforce planning in the report.

⁴¹ Queen Elizabeth Hospital NHS Foundation Trust, King's Lynn; Royal Surrey County Hospital NHS Foundation Trust, Guilford, Surrey; Alder Hey Children's NHS Foundation Trust; the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

In summary the interviewees presented a range of views on who held responsibility for ensuring that the nursing workforce is considered when new health policies are being developed. This included different perceptions on the role and accountability of the Chief Nursing Officers, the professional leads for nursing within each of the four countries. The low level of reported involvement of the Chief Nursing Officers (5/30 interviewees) could be interpreted as a weak professional nursing voice or a lack of awareness of the importance of robust workforce planning for nursing. Furthermore two of the three Chief Nursing Officers interviewed did not consider that it was their responsibility.

There was also a low level of reported responsibility, for ensuring that the nursing workforce is considered when new health policies are being developed, by Directors of Human Resources or Workforce Leads (5/30 interviewees).

These findings highlight the range of views that existed at the time of the interviews regarding who had the lead responsibility for ensuring that the nursing workforce was considered when new policies are being developed. This variability in reported responsibility has implications for the development of healthcare policies across the UK and for ensuring the required nursing workforce is available for implementation of these policies. The review of the small sample of Director of Nursing Job Descriptions highlighted that there was also variability in relation to responsibility for nursing workforce planning at NHS Trust level.

6.4.3 Workforce Planning Capacity

Workforce planning capacity relates to the resources available to undertake this function. The need to develop improved NHS workforce planning capacity has been cited in several publications (including House of Commons Health Committee 1999a; Department of Health 1999c, 2003a; House of Commons Health Committee 2007a; Tooke 2008; Department of Health

2008a; Welsh Assembly Government 2003a; National Assembly for Wales 2008; Imison, Buchan and Xavier 2009). During the interviews questions were posed about workforce planning capacity with the aim of gaining insight into interviewees' views on the sufficiency of current capacity within their respective countries, and to establish if devolution had impacted upon this. The responses received identified different issues in each of the four countries.

6.4.3.1 Workforce Planning Capacity in England

Four interviewees from England raised concerns that workforce planning capacity in NHS England had reduced as a result of organisational restructuring, whereby workforce planning expertise had been lost when organisations closed or were reconfigured (ENG02, ENG05, ENG06, ENG10). Responses included descriptions of how Workforce Development Confederations had been merged with Strategic Health Authorities and then underwent further re-organisation, all within a short period of time. Workforce planning was a function of the Workforce Development Confederations and subsequently this was incorporated into the duties of the Strategic Health Authorities.

When the interviews were undertaken in 2008, the ten Strategic Health Authorities in England continued to have devolved responsibility from the Department of Health to lead the workforce planning process through the development of annual strategic workforce plans for the NHS services in their respective regions. One interviewee summarised the position in relation to workforce planning capacity and capability at this time as being:

'so not only have you got a limited resource in the SHAs, there are very young organisations in terms of PCTs, most of whom don't have the knowledge, skills and expertise to be able to think creatively around commissioning of education to support health care delivery so I guess the challenge at the moment is that we have got two immature organisations in England, struggling to try and work out how do you predict, how do you create a workforce for the next 20 odd years and more importantly how do you take your existing workforce and develop it in such a way that it is able to deliver the new sorts of innovation and

the new sorts of healthcare delivery that's going to be required if we are going to be able to control the costs and cope' (ENG11).

This response presents a similar view to that in the House of Commons Health Committee inquiry on Workforce Planning in England (2007), which noted the damage to workforce planning systems and loss of workforce planning capacity which had resulted from repeated national NHS structural changes and organisational reconfigurations.

A study undertaken around the same time as the interviews also identified that the intermediate or regional tier in NHS England had been subject to frequent reorganisation and reform in a manner that impaired its effectiveness (Imison, Buchan and Xavier 2009).

In summary the issue reported by interviewees in England was the impact of successive reorganisations on workforce planning capacity and this situation had not improved following devolution.

6.4.3.2 Workforce Planning Capacity in Scotland

In Scotland three interviewees highlighted that there was sufficient workforce planning capacity but this needed to be integrated more within the three regional planning areas (North, East and West) and local organisations rather than being located centrally in the Workforce Planning Unit in the Scottish Government (SC04, SC05, SC06). Another interviewee welcomed the increase in workforce planning capacity that had occurred through the introduction of the regional planning teams but reported that it was too early to judge the impact of this resource (SC01).

As noted earlier the long established Student Nurse Intake Planning (SNIP) annual national planning process was in place in Scotland⁴². This was a demand led model which it was reported incorporated a degree of pragmatism towards the end of the process when government Ministers were

⁴² The Student Nurse Intake Planning process was introduced in 1996, prior to devolution.

asked to endorse or moderate the recommendations of the modeling on an annual basis (SC05).

The North of Scotland was identified by two interviewees as being an area of good practice for workforce planning (SC05, SC06). This was reportedly due to the collaborative working between workforce planners in NHS organisations in this region (SC06) and the integration of workforce planning and service planning responsibilities into the North of Scotland Regional Planning Lead role (SC05). Despite the reported success of this integrated lead role, this model had not been replicated in the other two regions of Scotland.

The view of three interviewees was that the workforce planning resources across NHSScotland were adequate, although it was suggested that some adjustments between national and regional resources were needed. A further interviewee was awaiting the outcomes from the new regional workforce planning teams. Changes which had been introduced since devolution included the establishment of three regional workforce planning areas and refinement of the pre-existing SNIP process. Despite this infrastructure it was reported that the outcomes of the workforce planning process were adjusted by government Ministers prior to final approval.

6.4.3.3 Workforce Planning Capacity in Wales

Some interviewees in Wales expressed concern about the limited workforce planning capacity in the NHS in Wales: *'Oh yes it's comprehensive! (laugh) Comprehensively not there!'* (WAL05) and *'there is one workforce planner in NLIAH⁴³ who's skilled in workforce planning for the whole of the NHS in Wales'* (WAL01). These comments were in line with 'the significant capacity shortcomings in workforce planning' described in the Wanless Review in 2003 (Welsh Assembly Government 2003a, p.2) and subsequently reinforced in the findings of the inquiry into health and social care workforce planning in

⁴³ National Leadership and Innovation Agency for Healthcare

Wales (National Assembly for Wales 2008), which highlighted the lack of capacity both centrally and at Local Health Board level.

At the time of the interviews in 2008, a new national approach to workforce planning was being implemented in Wales through the creation of a Workforce Development and Education Commissioning Unit (WDEC). The functions of this new unit included considering the workforce implications of national (Welsh) policies and strategies as well as providing a new workforce planning framework and analytical support to augment local workforce planning.

Interviewees in Wales reported that greater attention was being focused on increasing capacity with the creation of a Workforce Strategy group, a Workforce Planning Implementation group and plans to train additional workforce planners for Regions and Trusts in the country (WAL01, WAL05), but this was tempered with apprehension about the impact of the high turnover of key planning staff on overall workforce planning capacity (WAL04). One interviewee also noted that the National Partnership Forum in Wales paid *'lip service'* to workforce planning (WAL01).

The narrative from interviewees in Wales illustrated that there were persistent deficits in central workforce planning capacity. Changes were however planned to enhance the workforce planning capacity in local NHS organisations but at the time of the interviews there was no evidence of the impact of these changes.

6.4.3.4 Workforce Planning Capacity in Northern Ireland

In Northern Ireland similar challenges to Wales were identified with a lack of capacity at a national level (NI02) where the central resource was reported to be two people supported by an *'occasional secondee'* or *'consultants for the big reviews'* (NI01, NI05).

At the time of the interviews in 2008, the National Workforce Planning Unit within the Department of Health, Social Services and Public Safety carried out detailed reviews of the main clinical workforce groups on a three yearly basis, supplemented by annual reviews on a smaller scale. The most recent detailed review of the nursing workforce was published in 2005 (Department of Health, Social Services and Public Safety 2005c)⁴⁴.

Interviewees reported that, as part of organisational reconfiguration in Northern Ireland in 2008, each Trust was required to identify a lead for workforce planning within their Human Resources team (NI01, NI02, NI05) in an attempt to increase capacity, whilst training was provided in patient centred workforce planning through a post graduate diploma to improve capability (NI01, NI05). It was reported by one interviewee that in some organisations this new capacity was compromised where these workforce planning leads also held responsibilities for other unrelated functions such as bed management (NI02).

There were similarities between Wales and Northern Ireland, where interviewees from each country reported limited workforce planning capacity. In Wales this was identified as one workforce planner, whilst in Northern Ireland the national resource was reported as being a central unit with two staff. In Northern Ireland there was a planned approach to bringing in additional resources for the fuller NHS workforce reviews undertaken every three years, which was reliant on consultants external to the NHS. Both Wales and Northern Ireland had plans in place to develop workforce planning capacity within local NHS organisations. In Wales this was through the development of additional workforce planners, whilst in Northern Ireland it was planned that this would be delivered by combining workforce planning responsibility with other functions. At the time of the interviews these changes were in the process of being implemented in both countries.

⁴⁴ The year after the interviews a summary review of the nursing and midwifery workforce in Northern Ireland was published (DHSSPS 2009b).

6.4.3.5 Summary on Workforce Planning Capacity

In all countries other than Scotland, interviewees expressed concern about workforce planning capacity. If their views are representative of the situation at the time, it appears that the issue of lack of capacity had not been addressed adequately despite being raised in successive Health Committee reviews and workforce planning reports.

The deficits in dedicated capacity, the fact this group of staff had been subject to frequent reform, particularly in England, and the reality that responsibility for workforce planning was in some cases combined with other functions all contributed to the message that workforce planning was not valued enough. In addition to this there is no recognised career structure for workforce planners and the limited opportunities for existing staff could discourage new staff from entering the field of workforce planning. These deficits in workforce planning capacity were not limited to nursing workforce planning and consequently there were implications for workforce planning across the healthcare professions.

Within Scotland workforce planning capacity was reported by some interviewees as being satisfactory and this was most likely due to the expertise developed through the annual use of the long established SNIP process; the introduction of regional workforce planning teams; and a central Workforce Planning Unit within the Scottish Executive. Although the SNIP process was in place prior to devolution, the other changes in workforce planning structures and resources had occurred following the introduction of devolution in Scotland.

As highlighted in the responses from Scotland, even where there are established workforce planning structures and processes in place, the recommendations are subject to adjustment by government Ministers, particularly where reductions in nursing numbers or training places would be unpopular with trade unions and the public.

Overall the interview responses indicate that following devolution there were deficits in the workforce planning capacity in England, Wales and Northern Ireland.

6.4.4 Centralised versus Decentralised Workforce Planning

There has been continued debate over the merits of centralised versus decentralised workforce planning (including Buchan 2004, Tooke 2008). This issue was investigated during the interviews to identify if there was any change in perspective or resolution of this issue following devolution.

The centralised workforce planning model is based on control over the workforce planning process from a national body, generally the relevant government health department. Decentralised workforce planning is where the responsibility for this function has been devolved within the organisation to regional or local bodies for example to a Health Board, Strategic Health Authority, Trust or other local organisation. Centralised and decentralised workforce planning approaches are sometimes referred to as 'top-down' and 'bottom-up' planning. Scotland has adopted a mixed approach as demonstrated through its centralised workforce planning unit, three regional teams and the involvement of local NHS organisations in the annual SNIP process. Wales and Northern Ireland have central units in place to oversee nursing and other non medical workforce planning, whilst England has a decentralised system in place via the Strategic Health Authorities. Given the larger size of England it could be argued that this infrastructure is intermediate in a system that is just as centralised as Wales and Northern Ireland.

Approaches to nursing workforce planning can be centralised ('top down'), decentralised ('bottom up') or a combination of both. The viewpoints of interviewees on the ideal approach to nursing workforce planning will now be considered.

11 interviewees were supportive of a mixed approach to nursing workforce planning where some elements are centralised, whilst others are decentralised (ENG02, ENG04, ENG05, ENG09, ENG10, SC01, SC06, SC07, WAL06, NI03, NI04). The importance of having centrally produced standards or tools to support local planning was raised by three interviewees (ENG05, SC06, WAL06). Two interviewees highlighted the need to ensure that nursing workforce planning is carried out at the most appropriate level (ENG04, ENG08), whilst one interviewee noted that where there is an absence of central structures there could be duplication of activity (WAL06).

Where limited workforce planning capacity was reported in England, Wales and Northern Ireland (section 6.4.3) there is a case to be made for this limited resource being held at a central point rather than being dispersed to local organisations. There is no methodology for calculating the optimal workforce planning resource required within a country or how this resource should be split between centralised and decentralised structures. There was no evidence from the responses at interview that devolution had made any significant impact upon determining the optimal approach.

6.4.5 Integration of Workforce Planning

The need for better integration of workforce planning with service planning and financial planning was highlighted in several key reports identified in the literature review in chapter three (including Scottish Parliament Health Committee 2005; House of Commons Health Select Committee England 2007a; National Assembly for Wales 2008; Imison, Buchan and Xavier 2009). During the interviews the researcher sought to establish if this integration had occurred following devolution.

Although six interviewees reported the need for better integration between workforce, financial and service planning (ENG04, ENG06, ENG08, ENG09, SC05, NI01), it was reported that there were no established techniques to

support this (SC05, WAL04) and one interviewee even described it as '*the holy grail*' (ENG02). Despite the acknowledgement that better integration of workforce, financial and service planning was required; there was no recognised framework or model against which progress with integration could be monitored. An important factor impacting upon the extent of integration is the requirement to achieve financial balance in the annual accounting cycle, which frequently drives short-term decisions regarding the size and composition of the nursing workforce based on the financial envelope available (National Audit Office 2006).

6.4.5.1 Views on Integration of Workforce Planning

Four interviewees reported that service and financial plans did not take account of the workforce (ENG04, ENG09, WAL04, SC02). An interviewee from England described the clear disconnect between service, workforce and financial planning at an organisational level as being:

'some of the Trusts that were in difficulties were clearly struggling with that kind of alignment because you would find that the finance committee on one hand would be forecasting a huge deficit and yet at the same time you would have recruitment going on . . . and people still being brought into the Trust' (ENG09).

This local level example of target driven staffing growth occurring independently of local financial plans, played out across the NHS, was what contributed to the overshooting of the national *NHS plan* nursing workforce target in England.

The financial deficits in England, Scotland and Wales which emerged during 2005/6 and the Comprehensive Spending Review (CSR) in Northern Ireland published in 2007 were reported as having been key drivers for the improved integration of workforce, service and financial planning (ENG09, SC02, WAL06, NI02, NI06). Despite this, examples were provided of nursing posts being frozen (WAL06), skill mix reviews being undertaken to reduce the numbers of Registered Nurses (NI05) and nursing establishments which were based on historical figures or assumptions (ENG07), indicating that in

some cases workforce planning decisions were still being driven by the available finances as opposed to workforce and service requirements.

In Scotland it was reported that the Workforce Planning Framework and Local Delivery Plans (LDPs) had been introduced to support the triangulation of workforce, service and financial planning (SC02, SC04, SC06). However a barrier to this integrated planning was identified as being the variation in timeframes for completion of the different elements of the annual workforce, service and financial plans (SC06). This was reported to have resulted in Health Boards reallocating money from one area to another to meet short term financial pressures, described as the tendency to '*rob Peter to pay Paul*' (SC01) and this action hindered longer term, sustainable workforce planning decisions. The need for better alignment between workforce, service and financial planning timeframes was also identified in the Wanless Review in Wales (Welsh Assembly Government 2003a) and the House of Commons Health Committee report on workforce planning in England (2007a).

Although devolution had created greater flexibility which could in theory enable each country to develop its own approaches to integrating workforce, financial and service planning, there was no evidence from interviewees' responses that this integration had been achieved. Devolution did not appear to have had an effect on integration; instead workforce planning decisions were primarily being driven by tight financial pressures. As the majority of workforce planning structures and processes were in place in each country prior to devolution, the finding that devolution had not impacted upon this integration was not entirely surprising.

6.4.5.2 Multi-Professional Workforce Planning

Another issue identified in the review of literature was the lack of integration between medical and non-medical workforce planning (noted by e.g. House of Commons Health Committee 1999a, 2007a; Tooke 2008). Four interviewees were explicitly supportive of continuing to plan the nursing

workforce as a single profession and independently of other professions (SC04, WAL01, WAL04, WAL05). This finding contradicts the conventional wisdom that undertaking workforce planning in professional silos is bad and should be discouraged. One of the interviewees who supported planning in professional silos described the situation as:

'we were attempting to airbrush out the professions now I was clear . . .that this was unacceptable, we should not be embarrassed at all as nurses or doctors or physiotherapists or managers to be clear about what it is that we do and what we need to do it in terms of numbers and competencies because unless you do that you really cannot apply a generic workforce model' (SC04).

Two of the interviewees who also supported planning in professional silos, cited the need to maintain the future workforce supply of each professional group (WAL04, WAL05), whilst another interviewee reported that the reason planning in professional silos was being discouraged was that professional silos was *'a language for I can't afford you so I'll get a cheaper worker but I'll still need some of you to take the accountability and responsibility'* (WAL01), resulting in the greater use of skill mix within the healthcare workforce.

Support for the continuation of nursing workforce planning rather than integrated workforce planning across professions was most frequently reported from Wales where three out of six interviewees expressed this view. This response was in the context of an integrated senior professional leadership team at the Welsh Assembly Government, whereby the Chief Nursing Officer reported to the Chief Medical Officer. The support for undertaking nursing workforce planning as distinct from workforce planning for a range of professions could be based on an apprehension that nursing may be marginalised within wider workforce planning activities.

One of the challenges associated with workforce planning in professional silos is managing the implications of changes in planning one profession for planning in others. One example is *Modernising Medical Careers* (Department of Health 2004b) the new programme of post-graduate medical training introduced in 2005, which resulted in changes to the career

structures for doctors. The independent review into its implementation (Tooke 2008) acknowledged that in the future medical workforce planning should take account of impact on the roles of other healthcare professionals.

6.4.5.3 Summary on Integration

Feedback during the interviews clearly indicated that there was little reported evidence of integration of workforce, service and financial planning. Some interviewees' responses also highlighted that there was not full support for integrating workforce planning across professional groups, with some stating a clear preference for continued planning on the basis of individual professions.

6.4.6 Opportunities for Nursing Workforce Planning on a UK-Wide Basis

Historically nursing workforce planning has been carried out on a separate basis in each of the four countries. Questions were asked during the interviews to establish stakeholder views on UK-wide nursing workforce planning and if there was support for this approach following devolution. This was to ascertain interviewees' views on a more coordinated approach to nursing workforce planning between the four countries, as a supplement to the current processes within individual countries.

Four interviewees reported that they were supportive of nursing workforce planning being undertaken on a UK-wide basis as this would provide better mechanisms to: share workforce information about '*cross border flows and movement*' of nurses (ENG02); take account of the progress that has been made in the different countries (SC01); take cognisance of the different needs within countries (SC07) and develop work on a national UK-wide basis that each country could then contribute to (NI06). There would also be the potential for reduced duplication of effort within individual countries (NI06). One interviewee in England highlighted the need for '*more effective dialogue across the four countries*' particularly to identify risks but recognised the

political sensitivities associated with raising issues related to workforce planning across countries (ENG04).

The majority of responses to this line of questioning centered on the flow of Registered Nurses, across the UK, after they had been trained. One interviewee from Northern Ireland expressed reluctance at the possibility of a four country approach to workforce planning, citing concern that it could upset the balance of nursing workforce supply in the smaller countries (NI06). An interviewee from Wales reported a similar viewpoint and described the analogy that '*when England sneezes Wales catches a cold*' whereby nursing workforce shortages in England had consequences for recruitment in Wales, due to its close geographical proximity (WAL04). However nurses will move freely between countries regardless of whether there is a UK-wide workforce planning system or planning is undertaken within individual countries, as no country can be completely self-contained with a sealed labour market.

It was reported that England was a net importer of Registered Nurses and the other UK countries were apprehensive that expansion of the nursing workforce in England could be at their expense (ENG09, SC02). The impression that England was a net importer was based on the experiences of England's recruitment campaigns to meet the targets for nursing workforce growth set in *the NHS Plan* (Department of Health 2000a) and the subsequent policy *Delivering the NHS Plan* (Department of Health 2002a). An interviewee from Scotland acknowledged the need to be aware of each country's nursing workforce requirements but that UK-wide planning should not necessarily result in:

'a state of competition between countries where it is more attractive to be a nurse in Scotland than it is England or whatever so I think we have got to keep things as simple as possible' (SC07).

It could be argued that if effective nursing workforce planning was in place across the UK then the particular requirements of individual countries could be more effectively planned for but there would be a requirement for data

related to nursing workforce mobility to be captured and monitored. This could potentially reduce the need for one country to actively recruit nurses from the other countries thus addressing some of the concerns regarding the potential impact of England on the supply of nurses from the other three countries.

In the absence of UK-wide nursing workforce planning there are two forums where workforce planners can meet and share information at a UK level. One is the National Education Commissioners group and the other is the National Workforce Planners network. Both of these forums are based in England and representation from the other three countries is voluntary and therefore tends to be on an ad-hoc basis.

The National Education Commissioners group comprises the Strategic Health Authority Education Commissioning Leads who had responsibility for developing education and training plans, including the numbers of pre-registration training places which require to be commissioned each year. They meet as a group on a monthly basis to discuss the impact of current health policies on education and training for nursing and other non-medical professions and to share information on the planned education commissions for their respective organisations.

The National Workforce Planners' Network meets bi-monthly in London with the aim to: 'develop and champion high quality, integrated workforce planning by providing a forum for discussion, knowledge-sharing, professional support and decision making' (National Workforce Planners' Network 2011). Three interviewees reported that this four country National Workforce Planners Network was a useful forum for sharing ideas and common issues, including discussions with the Workforce Review Team (WRT)⁴⁵ (ENG10, NI02, NI04). It was also noted that England dominated the picture in terms of workforce numbers (ENG10) and one interviewee from Wales reported that: '*I inveigle*

⁴⁵ The Workforce Review Team has since been disbanded and a new organisation the Centre for Workforce Intelligence has been created.

myself in the English Workforce Planning network as a means of keeping in touch (1xWAL⁴⁶). An interviewee from Scotland reported that generally there was more contact with England than there was with Wales and Northern Ireland in relation to workforce planning discussions and sharing of information (SC05).

Overall only a small number of interviewees supported the idea of UK-wide nursing workforce planning, whilst others expressed concern at the impact of England on the post planning nursing workforce flows which existed due to the larger size of England compared to the other three countries. This concern had been influenced by the impact of England's aggressive nurse recruitment campaigns to meet the workforce targets set in *the NHS plan* and related policies. There was no evidence of strong support for UK-wide nursing workforce planning following devolution and interviewees continued to use informal networks to exchange information between countries on an ad-hoc basis. The preference for undertaking nursing workforce planning in individual countries was in line with the ethos of devolution and the focus on responding to the healthcare needs of the local population.

6.4.7 Summary of the Key Points Related to Nursing Workforce Planning

The two research questions being addressed in this section of the findings are:

- *What has been the impact of devolution on nursing workforce policy and planning across the four countries of the UK (1997-2009)?*
- *How and why have the approaches to nursing workforce planning changed across the four countries of the UK (1997-2009)?*

Overall the analysis of responses from interviewees reinforced that different planning approaches were being used in each of the four countries, in line with national policies and structures.

⁴⁶ Interviewee identifier has not been used to protect anonymity.

Interviewees reported a range of different views in relation to who held responsibility for ensuring the nursing workforce is considered when new health policies are being developed. The majority of interviewees cited that this responsibility was shared between individuals in specific roles, departments and organisations. A significant finding was that the majority of interviewees did not identify this function as being part of the Chief Nursing Officer's role. Furthermore two of the three Chief Nursing Officers interviewed did not report having responsibility for ensuring that the nursing workforce is considered during health policy development.

Previous research and the review of a small sample of four Director of Nursing job descriptions highlighted that many did not have responsibility for nursing workforce planning at an organisational level.

Another finding was that despite the rhetoric around the need to increase workforce planning capacity this was not reported as having been addressed effectively. The challenges related to a lack of adequate staff with the specialist knowledge of workforce planning methodology, reported in three of the four countries. This was reportedly compounded by the limited career development opportunities available for this staff group and the fact that the workforce planning structures in organisations were subject to frequent reform, particularly in England.

These findings highlighted that despite recommendations from Health Select Committees and other similar reports on the need for better integration of workforce planning with service and financial planning; this had still not been achieved in practice. The reason for this was that workforce plans were influenced principally by available finances, whilst the different planning cycles and timeframes limited full integration. Responses from interviewees, combined with evidence from nursing workforce data, demonstrated a significant lack of alignment between financial and workforce planning whereby organisations continued to recruit nurses despite financial deficits.

This type of action across the NHS in England resulted in the nursing workforce growth targets being exceeded. The consequences of this over-recruitment in England subsequently resulted in nursing posts being lost from organisations in response to the financial deficits. Thus affordability continued to be the deciding factor in determining the size of the nursing workforce.

There was support from some interviewees for the continuation of nursing workforce planning on the basis of a single profession as opposed to integrated planning across professional groups.

There was limited support from interviewees for UK-wide nursing workforce planning as a supplement to the established processes in individual countries.

Overall the findings from this thesis illustrate that following devolution there has not been any significant changes in nursing workforce planning across the four countries of the UK, other than limited examples of good practice within individual countries.

6.5 Nursing Recruitment and Retention

6.5.1 Introduction to Nursing Recruitment and Retention

As reported in (chapter five) over the period between the introduction of devolution in 1999 and the interviews in 2008, there was significant growth in the registered nursing workforce ranging from 18% in Scotland to 25% in England. This level of growth in the nursing workforce was delivered through a combination of recruitment and retention initiatives as outlined in the literature review (chapter three).

In order to help address the key research questions, and in line with the principles of realist review, interviewees were asked to identify the three most successful strategies for the recruitment and the three most successful

strategies for the retention of nurses over the ten year period prior to the interviews in 2008, with a particular focus on assessing the impact of devolution on this.

Responses are structured under headings of the nursing recruitment and retention strategies most commonly cited by interviewees; differences between the four countries have been highlighted. Some of the strategies were reported to have had a positive impact on both recruitment and retention, whilst others were reported to have had an impact on either recruitment or retention.

6.5.2 Nursing Recruitment and Retention Initiatives and Influencing Factors

6.5.2.1 Flexible Approaches to Training Nurses

13 out of 30 interviewees identified that the most frequently noted factor in recruitment and retention of the nursing workforce was the introduction of flexible approaches to training, particularly in terms of recruiting people from a broader range of backgrounds into nurse training (ENG03, ENG05, ENG07, ENG11, SC01, SC03, SC04, SC06, NI01, NI02, NI04, NI05, NI06). This was described by one interviewee as *'reaching out to communities that haven't necessarily thought about higher education before'* (ENG11).

The most frequently reported strategies were tailored education programmes and secondments for existing Healthcare Support Workers to become Registered Nurses (SC01, ENG03, ENG05) described as *'growing our own workforce'* (ENG07). Access to nursing programmes (SC04), nurse cadet schemes (ENG03) and vocational training (SC06, NI05) were also cited as important methods of increasing entry to the profession, along with flexible *'step on step off'* education programmes (SC01, ENG07). In Scotland and Northern Ireland specific mention was made of the Open University (OU) programme as being a good education initiative, which delivered nurse training in remote and rural areas (SC03, NI02, NI04, NI06). The OU

programmes only delivered small numbers of Registered Nurses but enabled local people in rural communities to enter nurse training.

These new approaches to nurse education and training were introduced following devolution and although devolution was reported earlier in this chapter to have resulted in increased flexibilities for nursing, it was not clear to what extent devolution had impacted directly on the development of these new education and training initiatives. It was clear however that these education and training initiatives were in direct response to the need to meet significant nursing workforce growth targets associated with the substantial investment provided shortly after devolution.

As a consequence of widening the entry gate to nursing, there was an increase in the number of older trainees (ENG11) and those with other commitments such as childcare (SC02). This change in the composition of trainees resulted in the need for different approaches including additional support for those who had been out of studying for a number of years and the provision of part-time programmes for some students. An interviewee from Northern Ireland (NI05) highlighted that as a result of the drive to widen the entry gate into nursing, a number of those entering pre-registration nursing programmes had previously failed to gain a nurse training place when they left school as they had not met the entry requirements. This illustrated a change in the entry requirements linked to the need to fill higher numbers of training places to deliver the significant levels of nursing workforce growth.

Related to this, the importance of good selection processes was raised (WAL01) along with the need to achieve a balance between academic qualifications and personal attributes (ENG11), including the qualities of caring and compassion (SC04). An interviewee from England cautioned that there was a *'limited ability to be very, very choosy about the students'* (ENG11), whilst in Wales and Northern Ireland there were reports of good numbers of high calibre applicants for nurse training places (WAL02, WAL03,

WAL06, NI01, NI02), although there was an underlying anxiety that they may be *'creaming off the top of the reservoir, time will tell and we'll have to be very aware of that'* (NI05). The responses from these interviewees indicate the potential variability in the quality of students entering pre-registration nursing programmes across the UK. The Royal College of Nursing Labour Market Review data (Buchan and Seccombe 2009) illustrated different rates of successful applications to pre-registration programmes in different UK countries. For example in 2008, 66% of applicants to pre-registration programmes in England were successful in gaining a place whilst only 51% of applicants in Wales were successful in gaining a training place in Wales.

The availability of bursary support was viewed by five interviewees as being a driver in attracting students onto nurse training programmes (ENG03, ENG09, WAL06, NI01, NI03) but there was a reported suspicion by three of these interviewees (ENG03, WAL06, NI03) that some students were attracted onto nursing programmes due to the bursary payments rather than a real desire to become a Registered Nurse, particularly as there was no requirement to repay the bursaries (Department of Health, Social Services and Public Safety 2005c).

6.5.2.2 Increased Funding for Nursing Recruitment and Retention

Overall 12 out of the 30 interviewees raised the impact of increased funding and associated targets on nursing recruitment and retention during the period under review. Interviewees specifically identified the key drivers as being increased financial investment (SC04, ENG06, NI02), *'a sector on the up'* (ENG06) and the fact that nursing was a *'boom area'* (SC03), whilst others cited *the NHS Plan* in England (ENG06, ENG09) and targets for nursing workforce growth (ENG04, WAL01, WAL02, WAL03) along with increased pre-registration nursing commissions (ENG10, NI03, NI05). These responses reflected the significant investment in the nursing workforce in the early part of the decade, which was highlighted in chapter five, and earlier in

this chapter the impact of increased investment in the nursing workforce was also identified, particularly in England.

6.5.2.3 International Nursing Recruitment

The analysis of nursing workforce data in chapter five illustrated that during the period 2000-2002 there was significant growth in international recruitment of nurses. In 2002, 15,064 (49%) of the initial entrants to the Nursing and Midwifery Council register were from overseas (outwith the European Union); however international recruitment then declined significantly and by 2008 this figure was 2,309 (9%) of the initial entrants.

International nursing recruitment was highlighted by eight interviewees as being a crucial means of bringing new nurses into the workforce (ENG02, ENG05, ENG07, ENG08, ENG09, ENG10, NI03, WAL03). Six of the eight interviewees who highlighted international recruitment were from England, which reflects that there had been an explicit policy focus on international recruitment in England, led by the Department of Health.

Responses from the interviewees indicated that there were different approaches to international recruitment across the UK. Most of this activity was in England but responses from Wales indicated overseas recruitment from Spain (WAL05) and the Philippines (WAL03, WAL04). No interviewees in Scotland made reference to any international recruitment activity.

6.5.2.4 Flexible Employment Practices

The contribution of flexible working to improved recruitment and retention was identified by six of the 30 interviewees as being an important factor (ENG01, ENG04, ENG05, ENG07, ENG08, ENG09). All six of the interviewees who raised the importance of flexible working practices were from England. The specific policy initiatives cited included: *Improving Working Lives* (Department of Health 1999d, 2000b) (ENG01, ENG04, ENG05, ENG07), equal opportunity legislation (ENG01) and the National

Childcare Strategy (ENG09). Although flexible working was highlighted as being important in England, the review of nursing workforce statistics in chapter five did not find evidence of increased rates of part-time working in response to such policies. It was however recognised that there were other types of flexible working including annualised hours and term time working but no data was collected on these practices nationally. No interviewees from the devolved nations of Scotland, Wales and Northern Ireland made reference to the importance of flexible working practices in supporting nursing recruitment and retention.

6.5.2.5 Preceptorship

Six interviewees linked the importance of a structured period of support for newly qualified nurses in the practice setting to improved retention rates (ENG02, ENG11, SC01, SC06, NI02, NI03). In Northern Ireland it was reported that substantial investment had been made in the infrastructure to support newly qualified nurses (NI02), whilst in Scotland an e-learning initiative called '*Flying Start*' had been introduced (SC06) and although there was interest from Wales on the transferability of this model (WAL03)⁴⁷ there was no evidence that this was ever adopted in Wales. However, following the interviews, a pilot of '*Flying Start England*' was undertaken in 2009, resulting in agreement that the model would be implemented across England. This implementation of '*Flying Start England*' was an example of innovation across boundaries.

Preceptorship is an important professional nursing issue, which is of relevance to newly qualified nurses across the UK. A consistent approach to preceptorship, based on the Nursing and Midwifery Council guidelines (2006), could be beneficial in supporting the professional development and mobility of newly qualified nurses across the four countries. Despite this a *Preceptorship Framework for Nursing, Midwifery and Allied Health*

⁴⁷ In Wales the term '*Flying Start*' related to interventions for children and families and not preceptorship.

Professions was developed and published solely within England (Department of Health 2010b).

6.5.2.6 Pressures of Work

All the initiatives reported as being important to nursing recruitment and retention detailed thus far, are examples of policy interventions. Seven interviewees raised issues related to pressures within the work environment and although these were not policy interventions they were also reported to have impacted adversely upon the retention of nurses. The reported pressures of work included:

- staff feeling overwhelmed at work (SC01) or pressured (NI02), due to high workloads (WAL03)
- insufficient staffing numbers (NI03)
- freezing of posts (WAL06)
- too many nurses having been stripped out of service (NI04)
- lack of support (NI02) and low morale (NI03)
- feeling '*besieged . . . and expected to do more with less*' principally due to the demands placed by other professional groups, particularly medicine (ENG03).

6.5.2.7 Additional Factors Impacting Upon Nursing Recruitment and Retention

In addition to the main factors already reported by interviewees as being important for recruiting and retaining nurses, a range of other key aspects were identified by interviewees. These were:

- the need for strong professional and clinical leadership (SC06, NI06), including direct feedback to nursing staff from Directors of Nursing (NI02)
- the importance of staff feeling valued (ENG01, SC01, NI06)
- supportive working environments (SC04, NI02) and being considered '*the employer of choice*' (WAL02).

Four interviewees, one from each country, raised concern regarding retention in the context of an aging nursing workforce (ENG04, SC06, WAL04, NI02). Nursing and Midwifery Council data illustrated, that in 1997 48% of Registered Nurses and Midwives were aged 40 years and above but by 2008 this figure had increased to 65%, with 17% of nurses and midwives being aged 55 years or above and nearing retirement.

6.5.3 Summary of Key Points on Nursing Recruitment and Retention

Although a range of recruitment and retention initiatives had been used to enable workforce growth across the four countries of the UK, the main driver for this workforce growth was the increased funding and associated targets for nursing workforce growth. This increased funding was introduced around the same time as devolution but was not attributed to devolution as it applied to the four UK countries. Additionally the aging profile of the nursing workforce in each of the four countries would have necessitated different approaches to nursing recruitment and retention, regardless of the presence of political devolution.

Devolution may however have provided increased freedoms to develop local solutions to deliver the workforce growth, in line with the contexts of individual countries. Examples of this were the different approaches to widening the access to pre-registration nurse training programmes or the extent of recruitment of internationally educated nurses.

6.6 Summary

This chapter presented the findings from the detailed analysis of the qualitative data from the 30 key informant interviews providing both a UK-wide and individual country perspectives. The structure followed was in line with the headings outlined in the conceptual framework described earlier (chapter one) which were:

- the impact of devolution upon nursing

- the health policies which have impacted most upon nursing since devolution
- changes to nursing workforce planning following devolution
- the most effective strategies for nursing recruitment and retention.

The key themes identified in this chapter on data analysis and reporting of findings will be considered in more detail in the following chapter which discusses the key findings from this research as they relate to the two research questions.

Chapter Seven - Key Findings

7.1 Overview

This chapter will summarise the key findings from the research and explore how these findings relate to the two research questions.

The key findings can be summarised under seven themes:

- changing patterns of power and influence
- extent of Chief Nursing Officer involvement in ensuring that the nursing workforce was considered during policy development
- minimal changes in approaches to nursing workforce planning following devolution, resulting in continued cycles of 'boom and bust' in the nursing workforce supply
- variable growth in the nursing workforce across the four UK countries
- reluctance to share and learn from good practice across countries
- the unwillingness of England to 'let go'
- the policies considered to have impacted most upon nursing following devolution

Each of these themes will be reviewed in more detail and related to the research questions:

- *What has been the impact of devolution on nursing workforce policy and planning across the four countries of the UK (1997-2009)?*
- *How and why have the approaches to nursing workforce policy and planning changed across the four countries of the UK (1997-2009)?*

Although the seven key themes are considered individually there are areas of overlap and inter-relationships between them.

7.2 Context of Findings

In considering the key findings from this thesis a few points of relevance are outlined below as a means of contextualising the findings.

Devolution did not directly affect England and therefore it only applied to 15% of the UK population (Paun and Hazell 2008). At the time of the interviews in 2008, devolution had been operational for nine years in Scotland and Wales, whilst in Northern Ireland it was suspended for approximately half of this time.

Early in the period under review, there was 'unprecedented' investment in the NHS across all four UK countries (Woods 2004), which resulted in expansion of the nursing workforce in each country.

As reported in the Research Approach Chapter (section 4.2.4.3) the professional background of the sample of interviewees included:

- 12 interviewees who were Registered Nurses
- 12 interviewees who had no nursing background
- 6 interviewees whose professional background was unclear.

This means that at least 40% of those with experience in the fields of nursing workforce policy and planning from across the UK, who were interviewed in this study, did not have a nursing qualification. The diversity in the interviewees' backgrounds brings an increased depth to this study as it reports viewpoints wider than the professional nursing perspective.

7.3 Changing Patterns of Power and Influence in Nursing

This thesis identified that with devolution there were changes in the patterns of power and influence, with implications for nursing workforce policy and planning. Two particular aspects of power and influence raised in this thesis will be considered in more detail:

- closer working relationships with politicians and government Ministers
- the role, impact and sphere of influence of the four country Chief Nursing Officers.

7.3.1 Closer Working Relationships with Politicians and Government Ministers

Through closer access to government Ministers in each of the four countries the interface between politicians and the public, including nurses, has grown. This was principally due to the closer proximity of politicians and Ministers to the local population compounded by the desire for Ministers to have a more direct role in overseeing some public services, including healthcare. The change created through devolution is that these were different politicians with a different, more local focus with the need to be seen to be acting on behalf of communities that were now politically more proximate than Westminster.

The final Nuffield Trust report on *Devolution and Health*, published in 2008, focused on the impact of political devolution on the health systems in the UK and one of the key findings was 'the shortening lines of accountability between elected health ministers, the health service, members of the legislature and the public' in Scotland, Wales and Northern Ireland (Jervis 2008, p.15). The findings from the interviewees match the Nuffield research, whilst adding a new dimension in that this thesis identified specific implications for the influencing potential of members of the nursing profession.

The closer access and proximity to politicians and Ministers has also had implications for professional organisations and trade unions whose traditional routes of campaigning and influence could have had the potential to be marginalised in the devolved administrations, particularly as members of the public, including individual nurses, have increased access to politicians. However this was not a finding of this thesis; it was reported that professional organisations and trade unions had adapted to the different political landscapes in each of the four countries. Senior staff within professional organisations and trade unions in Scotland, Wales and Northern Ireland, have continued to shift their sphere of influence and focus from Westminster to the devolved administrations at Holyrood, Cathays Park and Stormont.

Prior to devolution professional organisations and trade unions had offices in each of the four UK countries from which they conducted local business with the relevant NHS Management Executive team, however there were greater opportunities for engagement following devolution, particularly with government Ministers.

A number of strategies have been employed by these professional organisations and trade unions to maximise their potential to influence politicians and devolved government, for example by ensuring their organisation is represented on steering groups or working parties, where priorities are agreed and policies developed. Although these forums existed prior to devolution there were more opportunities for involvement following devolution. The growth in the use of Parliamentary Questions following devolution, as highlighted in this research, indicates that this was a popular means of raising issues.

This closer interaction with politicians and Ministers has enabled good working relationships to be developed between politicians and senior personnel in professional organisations and trade unions. A study of Stakeholder Engagement undertaken for the Department of Health, England identified that the quality of engagement was 'very personality driven' and 'reliant on the efforts of the stakeholder' (Jigsaw Research 2009, p.28).

In section 6.2.5 examples were provided of senior staff in each of the three devolved countries who, at various stages in their career, had worked for the government health department and also for the Royal College of Nursing in the same country. This can be interpreted as giving greater potential for closer working between organisations but there is a risk that these working relationships become 'too close' and ultimately less productive. It also suggests a limited availability of senior nurses to fill key posts in Scotland, Wales and Northern Ireland. Following the interviews in 2008 this limited talent pool of senior nurses has persisted in Scotland. A high profile example

of this was that a nurse from England was appointed as the Chief Nursing Officer in Scotland, in January 2010 after the post became vacant in March 2009.

7.3.2 The Role, Impact and Sphere of Influence of the Chief Nursing Officers
This thesis considered the role and sphere of influence of the Chief Nursing Officers, in relation to nursing workforce policy and planning, in each of the four countries following devolution. The assessment in this thesis reinforces the point that the Chief Nursing Officer focus is on working within the statute and limitations of his or her respective country. The role is first and foremost as a civil servant with responsibility to the administration and elected government within their country. However if the senior nursing leadership in the four countries does not exploit the opportunities for greater collaboration then there could be consequences for the nursing profession. For example the continued development of different nursing policies and new roles could restrict mobility of the registered nursing workforce across the UK and have implications for the future of UK-wide professional regulation and standards.

The Nuffield Trust report published in the same year as the key informant interviews also highlighted that although setting standards for training and regulation are reserved matters in the UK, the future sustainability of this arrangement is at risk due to the changing roles and structures in each of the countries (Greer and Trench 2008). An example cited in the Nuffield report was the development of a new community health nursing role in Scotland, which could have resulted in a situation whereby this new type of professional was unable to gain employment outwith Scotland whilst existing Health Visitors, School Nurses and District Nurses from other parts of the UK might have been unable to gain employment in these roles within Scotland. This particular concern did not materialise as the work to develop the new community nurse in Scotland was subsequently terminated but there is the possibility of a similar situation arising in the future as other new nursing roles are developed in line with local health policies.

One of the risks associated with individual countries developing new nursing roles to suit local healthcare needs is the potential for variances in quality of care delivery resulting from the different approaches. Despite the presence of devolution, patients and the public expect equity in the standards of NHS care across the UK (Schmueker and Adams 2005) and patient groups or professional organisations may lobby their local politicians where they have concerns about differential standards of care.

This thesis highlighted the tensions which existed between the four UK countries, each with its own diverging health and nursing policies, and the Nursing and Midwifery Council which has responsibility for UK-wide professional regulation and standard setting for nurse education. If in the future Scotland gains full independence then that would be the end of the UK and the Nursing and Midwifery Council would therefore cease to be the UK-wide regulator.

In the four countries, interviewees provided different views about the power and influencing ability of their respective Chief Nursing Officer specifically in relation to nursing workforce policy and planning. Interviewees from Wales reported that there was still a drive from England to influence nursing leadership in Wales. This could be due to the weaker leadership in Wales, as reported by some interviewees, or the fact that some stakeholders in England had not fully understood the implications of working within devolved structures, a point highlighted in the literature review (chapter three).

7.4 Chief Nursing Officer Involvement in Ensuring the Nursing Workforce was Considered During Policy Development

Based on the findings from the key informant interviews, this thesis highlighted a major gap in relation to nursing workforce policy and planning. This gap was the lack of professional engagement and responsibility for ensuring that when new health policies are developed the nursing workforce

implications are taken into account. Interviewees provided different views on who holds this responsibility and responses included government health departments; Ministers; Chief Nursing Officers; Directors of Human Resources or Workforce Leads and '*no-one*'.

In the context of this ambiguity over who has responsibility for ensuring the nursing workforce is considered during policy development, the reality is that no-one is taking this responsibility. Furthermore the low level of reporting of the Chief Nursing Officer's involvement indicates that the professional nursing voice at a national (country) level is virtually invisible in this process. This does however create opportunities for others for example professional organisations and trade unions to exert their power and influence in shaping nursing workforce policy.

Another finding from this thesis was that at government health department level in the four countries, the roles and responsibilities between the Chief Nursing Officer, Director of Workforce and Ministers, in relation to the nursing workforce are unclear. This ambiguity in relation to responsibility for the nursing workforce amongst senior nursing leaders and policy makers has potential implications for the future sustainability of the profession, both nationally and within local healthcare organisations.

7.5 Changes in Approaches to Nursing Workforce Planning Following Devolution

One aspect of this research study was to examine how and why approaches to nursing workforce planning had changed over the period under review and what impact devolution had on this. One of the key findings from this study was that there was little evidence of lessons being learned which were making any real difference to the effective planning of the future nursing workforce following devolution.

Nursing workforce decisions at both local and national levels are mainly influenced by available budgets. There is therefore a dissonance between the rhetoric around the need for improved integration between workforce, financial and service planning and the reality of how this is taken forward in practice. At a local level these decisions are often carried out in isolation from the formal workforce planning and education commissioning processes undertaken to determine the future numbers of training places agreed for each professional group annually. This thesis identified that since devolution there has been little or no improvement in the integration of workforce, service and financial planning meaning that short term affordability continued to be the principal determinant of policy and planning decisions related to the nursing workforce.

Additionally, although there were reports of initiatives to increase workforce planning capacity across the UK, interviewees in three of the four countries reported that this workforce planning capacity remained insufficient. The low value placed on the workforce planning function and the limited career opportunities for people who work in this area are likely to have affected this lack of capacity.

An interviewee from Scotland reported that where education commissioning has been informed by workforce planning processes there was undue influence of Ministers in moderating the final commissioning numbers agreed, whilst in Wales one interviewee reported that the National Partnership Forum paid '*lip service*' to workforce planning. It is therefore possible that interviewees' experiences of how these workforce planning decisions have been made has resulted in disillusionment and disengagement in the process contributing to the lack of ownership and uncertainty regarding where responsibility for nursing workforce policy and planning actually sits.

The main implication of the lack of improvement in approaches to nursing workforce planning was that the UK could continue to experience 'boom and

bust' cycles in the supply of Registered Nurses. Given the various factors listed there is a possibility of a return to 'bust':

- the current nursing workforce is aging
- higher numbers of nurses leaving than joining the register
- increasing numbers of nurses working overseas
- the potential for increased attrition on completion of nurse training associated with the award of a degree qualification
- more opportunities for nurses to gain employment outwith the NHS, particularly in England
- growing pressure for improved nurse staffing levels
- the possible impact of shortages in medical staffing on the nursing workforce, particularly in the specialties of emergency medicine, primary care and psychiatry.

Owing to the lead in time to commission and train additional Registered Nurses, previous 'busts' in nursing workforce supply have necessitated a reliance on aggressive international nursing recruitment to fill vacancies, particularly in England. There is a high likelihood that there will be a return to international nursing recruitment to meet the nursing workforce supply needs in the near future.

An additional risk to future nursing supply is that UK trained nurses are actively recruited by other countries and the policy to develop a new type of Registered Nurse educated to degree level deemed to be a critical thinker, leading and managing teams and delivering high quality care in new ways (Long 2010), may make them even more marketable overseas. There is however no evidence available to suggest that this risk has materialised.

Despite the increasing age profile of the registered nursing workforce and the higher proportion of nurses nearing retirement, none of the interviewees mentioned any targeted strategies to retain older nurses in the workforce for longer. Additionally as highlighted in chapter five, the policies aimed at

increasing part-time working did not appear to have resulted in increased rates of part-time working. Lessons could be learned from international best practice for example the work successfully undertaken in Ontario, Canada to introduce a *Late Career Initiative* or *80:20 scheme* in which adjustments were made to the roles of nurses aged 55 and over, enabling them to work 80% of the time in their normal role whilst the other 20% was allocated to project work, teaching, audit or similar types of activity which were less physically demanding than direct patient care particularly in acute hospital settings (Bournes and Ferguson-Paré 2007; O'Brien-Pallas et al. 2007).

7.6 Variable Growth in the Nursing Workforce across the UK

Over the period under review variable rates of workforce growth were recorded in the four countries, and also differing registered:non registered skill mix ratios. Although England had the largest rate of growth in the registered nursing workforce with a 25% increase between 1999 and the interviews in 2008, it also had the lowest skill mix ratio with Registered Nurses and Midwives equating to 70% of the total nursing and midwifery workforce in 2008. The variability in the levels of growth in the nursing workforce across the UK, along with the different skill mix ratios could have consequences for the quality of patient care and the future unity of the nursing profession. Although there were differences in the composition of the nursing workforce prior to devolution, the increased responsiveness to local healthcare needs following devolution could result in greater differences in the nursing workforce between the four countries in the future. This will have particular implications if workforce planning decisions continue to be driven principally by affordability in a culture where there is a lack of clarity regarding responsibility for ensuring that the nursing workforce is considered during policy development. These differences in the composition of the nursing workforce may also be affected by the ambiguity over the accountability for nursing workforce planning within local NHS organisations.

A study on NHS performance undertaken by the Nuffield Trust reported higher levels of 'crude productivity'⁴⁸ in nursing in England, when compared to the other three UK countries. This was based on an assessment of nursing staff:population ratios applied to hospital in-patient, day case and out-patient activity (Connolly, Bevan and Mays 2010, p.25). It is likely that this type of nursing workforce comparison will become more common in the future particularly in view of increased financial pressures. However the critical dimension omitted from this study was the impact of these variations in nurse staffing on the quality of patient care in each of the four countries.

7.7 Reluctance to Share and Learn from Good Practice across Countries

Another theme which emerged from this thesis was the reported reluctance to learn from good practice and to share work across the four countries. There were barriers to adoption and spread at a national, four country, level even when all the Chief Nursing Officers were ostensibly 'signed up' to working collaboratively as in the case of *Modernising Nursing Careers*. These barriers include the NHS culture, resistance to change, poor sharing of information and professional rivalry (Greenhalgh et al. 2004; Gollop et al. 2004; Williams, de Silva and Ham 2010). Interviewees reported that the *Modernising Nursing Careers* policy was driven principally by England, which may have been a factor influencing engagement with its implementation including the willingness to share work between countries.

This thesis highlighted that devolution has resulted in divergence both in health and nursing policy which created increased opportunities for innovation within individual countries. This divergence occurred as policy solutions were identified to meet the specific needs of local populations, including the development of new roles or recruitment and retention strategies tailored to local requirements. The desire for the devolved administrations to develop local solutions to meet local needs has resulted in

⁴⁸ Crude productivity was referred to as the 'level of activity per staff member' (Connolly, Bevan and Mays 2010, p.25).

a culture where good practice in relation to nursing workforce policy and planning is not shared widely between the four UK countries.

The notion of sharing good practice and learning from experience was raised in the Institute for Public Policy Research report on public policy difference in the UK which suggested that:

‘devolution provides an opportunity for genuine policy learning, so what works well in one place can be adapted and implemented elsewhere. Equally lessons can be learned about what works less well too’ (IPPR 2008, p.4).

The findings from this thesis suggest that despite the opportunity for learning across countries enhanced through devolution, there was limited evidence of this taking place. This disinclination to adopt the work of one country and apply it to the context of another country is replicated at different levels across the NHS. Even within countries there were examples where good practice has not been transferred from one organisation to another.

The policy drive for increased competition in the NHS in England, demonstrated in part through growing numbers of Foundation Trusts, is another barrier to collaborative working and the sharing of good practice between NHS organisations. This is principally due to the fact that as these organisations compete for business and aspire to be ‘the best’, sharing of information may be considered as giving other organisations a competitive advantage.

The findings from this thesis indicate that despite the opportunities created through devolution for innovation, there was reluctance for the resultant good practice to be shared between the four countries with the potential for duplication of effort across the UK.

7.8 Unwillingness of England to ‘Let Go’

Although devolution created the opportunity for greater freedom to determine health policies within the devolved administrations, there were repeated

instances reported in this thesis of policy makers and key stakeholders in England who were unwilling to 'let go' and who still tried to direct the nursing workforce policy and planning agenda across the UK. The most likely reason for this was that these policy makers and stakeholders from England did not fully understand the implications of working with the devolved nations and how the role of England had changed. Related to this was the need for policy makers, particularly in England, to have a clearer understanding of reserved and devolved powers (Greer and Trench 2008).

This lack of clarity about England's role in relation to the devolved nations was perpetuated within the Department of Health, England (Jervis 2008). This indicates that there remains a need for increased transparency in relation to the roles and responsibilities of the staff within the Department of Health in England vis-à-vis the health departments of the devolved administrations. In addition to this there is a need for key individuals in these departments to commit to work within these parameters.

Another point that emerged from the review and interviews is that organisations with a UK-wide remit, such as the Nursing and Midwifery Council, need to develop a clear understanding of the policy priorities and contexts within each of the four countries and avoid any risk of having an 'England centric' approach. This also has implications for committees or groups established to provide advice on nursing policy development and implementation on UK-wide matters. Issues such as the choice of chairmanship and membership to ensure true representation across the four countries have to be considered.

The majority of healthcare and nursing organisations with a UK-wide remit have headquarters in England and even where organisations have adapted their structures to be more responsive to the needs of the devolved nations, in some instances it has taken several years for these changes to be introduced. An example of this is the Nursing and Midwifery Council did not

appoint an Assistant Director for Scotland and Northern Ireland Affairs or open an office in Edinburgh until January 2011, more than a decade after the introduction of devolution.

7.9 Policies Reported to have Impacted Most Upon Nursing

7.9.1 Policies Regarded as Important

Interviewees were asked to identify the three policies, which in their opinion had the most significant impact upon nursing over the period under review. Whilst a broad range of policies and policy drivers were reported, the two most commonly reported main policy drivers were:

- shift in care from acute hospitals into the community setting
- the changing role of nurses including the impact of reductions in junior doctor's working hours.

The potential implications of the shift in care from acute to community for the nursing workforce are considerable and include education and training of existing staff to work in new ways and in different care settings. Although this policy has been in discussion for many years, it has not been widely implemented and this is partly attributable to the nursing workforce, with the required skill set, not being in place to deliver this change in the location and focus of care. Moreover it demonstrates a disconnect between service and workforce planning and illustrates the implications of policy development in isolation from an assurance that the culture and infrastructure are in place to support the policy implementation. The new standards for pre-registration nurse education (Nursing and Midwifery Council 2010) include a greater emphasis on preparing nurses to work in community settings but the potential benefits of this new training have yet to be realised in practice.

The second most commonly reported policy driver was the changing role of nurses in response to policies including *the NHS Plan* in England (Department of Health 2000a); *European Working Time Directive* (Council Directive 1993); *Modernising Medical Careers* (Department of Health 2004b)

and the associated reductions in the working hours of junior medical staff. These policies enabled nurses to take on greater responsibilities including non-medical prescribing and the creation of new advanced practice roles but this was mainly as a consequence of nursing reacting to changes created by medical colleagues rather than the nursing profession being clear about the roles and career pathways of nurses vis-à-vis other professions.

Overall a wide range of policies and policy drivers were reported as being important to nursing, with no readily identifiable policy themes in Scotland or Northern Ireland. This was in part due to the large volume of policies developed in each of the four countries following devolution and the associated increased pace of change.

7.9.2 Policies Regarded as Unimportant

Several national policies and strategies were either not reported or reported by only a small number of interviewees, when they were asked their views on the three main policies to have influenced nursing over the period of the study. The low level of reporting of policies which outline the strategic vision for the nursing profession was a particular finding of this thesis. Furthermore none of the Chief Nursing Officers interviewed highlighted the Nursing Strategy within their respective countries as being a key policy. The most likely reason that the Nursing Strategies were only identified by a small number of interviewees was the time lapse between their publication and the interviews, resulting in some interviewees not being familiar with these strategies.

Despite *Modernising Nursing Careers* being current policy at the time of the interviews⁴⁹, it was only reported by three interviewees as being an important policy for nursing. This highlighted a wider problem with the profile and perceived importance of nursing policies. The low value placed on these nursing policies, combined with the lack of ownership for ensuring that the

⁴⁹ Although *Modernising Nursing Careers* was published in 2006, it was implemented between this date and 2010.

nursing workforce is effectively considered when new health policies are being developed, perpetuates the position whereby the nursing profession reacts to the demands of health policies. This is as a result of the absence of an agreed strategic vision which is endorsed by the profession in each of the four countries or across the UK. This has consequences for the future development of the nursing workforce including approaches to determining nursing workforce planning, skill mix, scope of practice, new nursing roles and recruitment and retention.

This chapter identified and summarised the key findings from this thesis in response to the two research questions set at the outset of this research. The next chapter provides the researcher's reflection on the realist review methodology; her dual role as a practitioner and researcher, followed by her views on the limitations of the study.

Chapter Eight – The Researcher’s Reflection

8.1 The Contexts within Realist Review

As detailed in chapter four (Section 4.1.5), a key requirement in realist review is the need for the researcher to take account of the different ‘layers of social reality’ surrounding interventions (Pawson and Tilley 2004, p.4). These can result in an intervention being more or less successful, depending on the context in which it has been implemented. Pawson et al. (2005) described these contexts as including:

- ‘policy timing
- organisational culture and leadership
- resource allocation
- staffing levels and capabilities
- interpersonal relationships
- competing local priorities and influences’ (p.23).

Although these contexts have been listed individually, in reality they are closely linked and interdependent. The researcher has reflected on the impact of the contexts detailed by Pawson et al. (2005), on this particular study and her conclusions are summarised below:

- **policy timing** – in this thesis it was not only the timing of the policy which had an impact but also the extent of policy making and implementation activity, as demonstrated through the policy logs for each of the four countries and the broad range of responses from interviewees in relation to the most important policies to have impacted upon nursing. This increased policy activity has implications for Chief Nursing Officers and their teams, who have limited capacity to ensure that the nursing workforce is considered at the policy design and implementation stages. Reflections from this thesis would extend this context to: policy timing and extent of policy activity.

- **organisational culture and leadership** – the level of importance placed on nursing workforce policy and planning was influenced by culture and leadership. In relation to this thesis the organisational culture and leadership was considered as being that which existed within each of the four UK countries. In addition to the organisational culture, nursing workforce policy and planning was influenced by the political climate in each of the four UK countries and the resultant policy priorities.

This thesis considered the leadership role of the Chief Nursing Officers in relation to nursing workforce policy and planning and interviewees' responses highlighted different perceptions of the strength of this leadership in different countries. There was also a range of different views from interviewees on who held responsibility for ensuring that the nursing workforce was considered during the development of new health policies. The lack of clarity on who held responsibility, as identified by interviewees, has resulted in deficits in the policy planning process with the potential for challenges in securing the required number of nurses with the necessary knowledge and skills for successful implementation of the policies, within the identified timeframes. Reflections from this thesis would extend this context to: organisational culture, leadership and political arena.

- **resource allocation** – this thesis identified that nursing workforce planning decisions were being disproportionately influenced by available financial resources rather than being truly integrated with service planning decisions. This was despite repeated recommendations, in a range of reports referred to in the literature review that workforce, service and financial planning should be more closely integrated. Utilisation of the allocated funding was also important and, during the period under review, there were examples where patterns of resource allocation were adjusted due to critical

changes in the economy, impacting directly on patterns of nursing recruitment and retention.

Related to the effective utilisation of financial resources, was the need for robust governance and monitoring systems. This thesis illustrated the lack of effective governance in relation to workforce planning at a local level which resulted in nursing recruitment continuing when organisations had ‘vacancy freezes’ due to financial pressures. Similarly on a national basis in England, the nursing workforce growth targets in *the NHS plan* (Department of Health 2000a) were hugely exceeded, which was in part attributable to deficiencies in governance and monitoring systems. Reflections from this thesis would extend this context to: resource allocation, utilisation and monitoring.

- **staffing levels and capabilities** – in common with the findings of earlier reports, as detailed in the literature review, this thesis highlighted that there was insufficient staff with workforce planning skills in the NHS in three of the four countries. Additionally, in terms of wider responsibility for workforce planning amongst nurse leaders in the four UK countries, there was limited capacity for this due to other work pressures and priorities.

A broader issue in relation to staffing identified in the devolved administrations was the limited talent pool available to fill senior nursing roles. This was demonstrated in part through the movement of senior staff between the Royal College of Nursing and the respective government health department in each of the devolved countries. Reflections from this thesis would extend this context to: staffing levels, capabilities and capacity.

- **interpersonal relationships** – the closer proximity of politicians in the devolved administrations to members of the public, including nurses, and professional organisations or trade unions had implications for influencing policy decisions. Professional organisations exploited these opportunities for closer working to influence policy priorities. Furthermore the movement of senior nurses between the Royal College of Nursing and the government health departments in the devolved administrations created further opportunities for close interpersonal relationships and influencing ability. Reflections from this thesis would amend this context to: interpersonal relationships and patterns of power and influence.

- **competing local priorities and influences** – following devolution the Chief Nursing Officers in each of the four countries continued to have primary responsibility to the health departments and governments of their respective countries. As highlighted under the policy context section above, there was a reported increase in policy activity following devolution. Related to this was the potential for shortages of nurses with the necessary clinical skills to deliver all of these policy commitments, particular as many policies had implications for nurse education and training with 'lead in' times to develop and deliver this training.

An example of competing policy priorities was the changes within the medical profession including medical workforce policies, during the period under review, which resulted in an increased demand for nurses across the four countries of the UK but this was not factored into the nursing workforce planning requirements. This highlights the need for a more integrated multi-professional approach to workforce planning to ensure that the demands of other professions on the nursing workforce are considered and planned for. Reflections from

this thesis would amend this context to: competing local priorities and influences across professional boundaries.

In addition to the contexts suggested by Pawson et al. (2005), the analysis conducted for this thesis highlighted the influence of **inter-country collaborations**. This was identified through interviewees' perceptions of the lack of collaboration on a four country basis, resulting in a reluctance to share good practice between countries. This was becoming more pronounced as the implementation of devolution meant that each country was developing its own unique identity in relation to healthcare policies and delivery, with implications for the nursing workforce. Reflections from this thesis would amend the contexts listed to include: inter-country collaborations.

On reviewing the contexts referred to by Pawson et al. (2005), the researcher proposes the following amendments to reflect the contexts of this particular study:

- policy timing and *extent of policy activity*
- organisational culture, leadership *and political arena*
- resource allocation, *utilisation and monitoring*
- staffing levels, capabilities *and capacity*
- interpersonal relationships and *patterns of power and influence*
- competing local priorities and influences *across professional boundaries*.
- *inter-country collaborations*.

8.2 Reflection on Dual Role of Practitioner and Researcher

From the outset of this study the researcher was aware of the potential for tension owing to her dual role as a practitioner in nursing workforce policy and planning and as a researcher in this area. Through reflexivity the researcher regularly considered the impact of her actions on how the research study evolved. Reflexivity reminded the researcher of the need to be 'attentive to and conscious of the cultural, political, social, linguistic, and

ideological origins of one's own perspective and voices of those one interviews and those to whom one reports' (Patton 2002, p. 65).

Finlay described reflexivity as being useful in considering the impact of the 'position, perspective and presence of the researcher' (2002a, p.532), whilst raising awareness of 'unconscious motivations and implicit biases in the researcher's approach' (2002b, p.225). Reflexivity enabled the researcher to consider the merits of being an 'insider' researcher, which included the ability to ask more 'meaningful questions' through having an 'authentic understanding' of nursing workforce policy and planning. However the researcher recognised that there were also benefits associated with being an 'outsider' researcher which included being less immersed in the subject matter, having a greater 'curiosity of the unfamiliar' and the potential to persuade interviewees 'to give fuller explanations' (Merriam et al. 2001, p. 411). The researcher was mindful of this dichotomy during the policy analysis work; the development of the interview schedule; whilst undertaking the interviews, the analysis of data and the reporting of findings. The researcher found that the realist review approach of considering what works for who, in what circumstances and why (Pawson et al. 2005), enabled her to be both rigorous and reflective throughout the research process.

An example of this reflection is that during the early phase of the research and prior to the researcher contacting prospective interviewees to request their participation in the study, a flyer (Appendix IX) prepared by the researcher was emailed from the office of the Chief Nursing Officer in Scotland to the offices of the other three Chief Nursing Officers. The aim of this communication was to raise awareness of the research and to encourage participation from key individuals in the other UK countries. This flyer and the subsequent communications to prospective interviewees clearly detailed that the researcher was undertaking the study independently, however with hindsight the researcher acknowledges that the fact that the

flyer was issued from the office of the Scottish Chief Nursing Officer could have influenced the initial perception of the work.

8.3 The Limitations of this Study

The researcher has identified limitations in the study design; research framework and data analysis which have impacted upon the findings of the thesis. The main basis of the findings is the data obtained from the interviews, which were conducted in 2008. There is therefore a need to exercise caution in ascribing too much weight to responses from interviewees when they were considering events that had occurred in earlier years, and where the number of responses are small. In order to contextualise this, the inclusion of nursing workforce data, health policy analysis and relevant literature from across the study period was used to provide background information.

As the research covered the four UK countries over a 12 year period there was a vast number of healthcare policies to be analysed and synthesised and there was also a need to identify and analyse relevant data in relation to nursing workforce policy and planning. With hindsight the researcher acknowledges that the inclusion of four country data across a 12 year period was ambitious for a single researcher; however it supported the development of a UK-wide perspective that would not have been possible if only one of the devolved countries was reviewed and compared to England.

Most of the examples in the literature about the use of realist review (including McEvoy and Richards 2003; Greenhalgh, Kristjansson and Robinson 2007; Wong, Greenhalgh and Pawson 2010) relate to the impact or evaluation of one particular policy or a suite of related policies. The scope of this study was much broader as it spanned four different healthcare systems, over a period of 12 years at a time of significant political change (the introduction of devolution). It was therefore only possible to apply the principles of realist review at a broader level.

The semi-structured interview method used meant that not all interviewees were asked exactly the same set of questions. The main benefits of this approach were the ability to include new lines of enquiry in response to points raised by interviewees and the rich source of information generated as a result. The disadvantages were that it was not always possible to make a 'like for like' comparison or report the full strength of response on all issues.

Additional work was created for the researcher by asking each interviewee to approve the transcript once it was typed up. This could have been avoided if in the initial consent form included agreement for transcription of the interviews, without a requirement for this final approval.

The researcher's expertise in conducting the interviews may have improved over the duration of the fieldwork. The personal experience of the researcher was such that it did not feel markedly different during the later interviews but it is an area worthy of consideration.

It is recognised that the interpretation of the findings of this thesis is underpinned and influenced by the researcher's professional background, personal experience and knowledge of nursing workforce policy and planning. This may mean that the researcher had access to contextual information not available to some of the interviewees for example experience of working within the Scottish Executive Health Department, NHS Trusts and a Multi-Professional Deanery meant that the researcher had direct involvement in the development and implementation of some nursing policies. This experience included responsibility for a national workforce planning project in Scotland and the commissioning of new graduate entry nurse education programmes across a region in England. The researcher's detailed knowledge of Scotland and England meant that there was a bias towards these two countries in terms of the researcher's level of understanding.

With hindsight there were two particular lines of questioning which should also have been covered in the interviews:

- the usefulness and / or quality of nursing workforce data
- what training was available and accessed by nurses in relation to nursing workforce planning systems, techniques and principles?

These omissions were not raised by interviewees and were identified by the researcher only after reflecting on the work undertaken.

In this chapter the researcher reflected on the contexts of realist review as they applied to this research and described the limitations of the study. This is now followed by the final chapter which details the overall conclusions of this thesis.

9.0 Chapter Nine Conclusions and Recommendations

9.1 Conclusions

This thesis was undertaken to examine the impact of devolution on nursing workforce policy and planning across the four UK countries over the period 1997-2009. This topic was chosen for two reasons, firstly it was in response to an absence of other research in this area and secondly it was an area of professional interest to the researcher.

At the outset of the study a conceptual framework was developed to ensure a consistent approach was used in the literature review, the data analysis and reporting of findings. A purposive sample of 30 interviewees was selected from across the four countries of the UK. Interviewees were chosen for their knowledge and experience of nursing workforce policy and planning in their respective countries.

A mixed methods research approach was adopted whereby the qualitative data from the 30 interviews was contextualised with quantitative nursing workforce data and the synthesis of key themes from health policies from each of the four countries. A realist review approach was used as a means of understanding and explaining the relationship between the context of interventions, the mechanism through which it works and the resultant outcome (Pawson et al. 2005).

The findings of this thesis are summarised under the two research questions posed at the outset of the study. The first research question is:

- *What has been the impact of devolution on nursing workforce policy and planning across the four countries of the UK (1997-2009)?*

Devolution has resulted in divergence in both health and nursing policy across the four UK countries which created the ability for each country to be more responsive to the specific healthcare needs of its local population. This increased flexibility resulted in greater opportunities for innovation within

nursing through for example the development of new nursing roles and different approaches to nursing workforce planning. However as nursing regulation is a reserved function, the development of new nursing roles in each country remains constrained by the UK-wide regulatory framework.

Despite the examples of innovation within nursing workforce policy and planning, including the different approaches to developing the community nursing workforce, there was only limited evidence of the four UK countries learning from each other. Although some information on the different nursing policy initiatives was available; there was limited adoption of these initiatives between countries. A wider report on devolution in health cited 'defensiveness over difference' as being a contributory factor (Timmins 2013, p.1). The findings from this thesis were similar as the policy divergence between countries has resulted in increased legitimacy in relation to difference, which has hindered this sharing and adopting good practice from other countries.

Over the period since devolution was introduced, there was also a lack of four country nursing policy collaboration, whereby *Modernising Nursing Careers* was the only example of UK-wide nursing policy collaboration following devolution. As detailed earlier in chapter six (section 6.2.4.2), the outputs of this work were minimal on a UK-wide basis.

Another area of potential collaboration was for UK-wide nursing workforce planning as a supplement to the current systems within individual countries. This UK-wide approach has never existed and there was limited support from interviewees for its introduction. However such an approach may have created the opportunity to be more responsive on a UK-wide basis, reducing the reliance on overseas recruitment in response to deficits in nursing workforce supply which have resulted from poor nursing workforce planning.

One of the main changes in the nursing workforce over the period of this study was the significant growth in the nursing numbers, which was as a result of substantial funding increases in the NHS in each of the four countries. The allocation of this funding within each country was a devolved decision and although each of the four countries invested in the nursing workforce, the percentage growth differed between countries for both the registered and non registered workforce. An example of this is that over the period 1999-2008, the registered nursing workforce in England grew by 25% compared with an increase of 18% in Scotland. Despite this growth in Registered Nurses, England had the lowest percentage of Registered Nurses relative to the total nursing workforce which increased from 66% in 1999 to 70% in 2008. This was significantly lower than the position in Northern Ireland which consistently had 77% Registered Nurses in its total nursing workforce across the study period.

Through devolution the policy making environment had changed and there was associated divergence in both health and nursing policies across the four UK countries. Access to politicians had also changed following devolution with the emergence of new opportunities for influence as highlighted in this thesis. However neither of these factors has led to changes in nursing workforce planning.

The finding that only 13 interviewees were explicitly positive about the impact of devolution upon nursing, whilst five interviewees commented specifically on its negative impact and the remaining 13⁵⁰ did not respond does not indicate overall frequent support amongst the interviewees for devolution having had a positive impact upon nursing.

⁵⁰ One interviewee cited positive and negative views on devolution's impact upon nursing.

The second research question is:

- *How and why have the approaches to nursing workforce policy and planning changed across the four countries of the UK (1997-2009)?*

The actual immediate impact of devolution on nursing workforce policy and planning was limited. Prior to devolution, each of the four UK countries had separate systems in place for nursing workforce policy and planning. Therefore devolution did not require the break up of a UK-wide system or the establishment of four new systems.

The findings from this thesis demonstrate that despite all the rhetoric around the need to improve nursing workforce planning, there was very little reported progress on the main areas of concern as highlighted in the numerous reviews of NHS workforce planning detailed in the literature review (chapter three). This included the continued lack of integration between workforce, financial and service planning which resulted in the position whereby nursing workforce planning decisions were unduly influenced by available finances, rather than being based on the care needs of patients. There was a lack of consensus both from the literature on workforce planning and from interviewees in this thesis regarding whether nursing workforce planning should be a centralised ('top down') or decentralised ('bottom up') function and there were mixed opinions regarding the integration of nursing workforce planning with workforce planning processes for other professions. Inadequate workforce planning capacity remained an issue in three out of the four UK countries, reinforcing the low value placed on the workforce planning function.

Devolution could have led to more responsive, flexible locally driven nursing workforce policy and planning but this did not happen. Although there have been a range of different policy responses in each of the four countries there has been a lack of evidence of sustained improvements in nursing workforce policy and planning as a consequence of these different approaches. As a

result of this poor planning, there were continued cycles of 'boom and bust' in the supply of the nursing workforce. One of the main factors contributing to the repeated issues with nursing workforce planning was the lack of clarity regarding responsibility for this function at both national and local levels.

The findings of this thesis indicate that although there were variations in the approaches to workforce policy and planning taken in each of the four countries resulting in for example different levels of workforce growth and different workforce profiles in each country, devolution has not had a significant effect upon nursing workforce policy and planning in the UK. There was no reported evidence to demonstrate that the different policy approaches; the different workforce planning structures and processes or the use of workforce planning tools were making any real measurable difference or delivering sustained improvements in nursing workforce policy and planning.

Neither was there evidence that policies within each of the four countries, which aimed to deliver improvements in workforce planning, were being monitored or evaluated in any systematic way. This has resulted in recurrence of the same deficits in nursing workforce planning which have been compounded by the lack of clarity regarding responsibility.

The impact of devolution on nursing workforce policy and planning has remained an under-researched area. The implications of devolution on NHS workforce planning more generally, is also an area which has not been addressed in the research literature. A recent paper from the King's Fund described research on the differences between the four health systems in the UK as 'a woefully under-explored area'. One of the findings from the King's Fund paper was that learning between the health systems had occurred 'albeit indirectly and despite great reluctance to share knowledge' (Timmins 2013).

The reluctance to share and learn from good practice across nursing workforce policy and planning was a key finding from this thesis. For example there was little evidence of the component workstreams from the *Modernising Nursing Careers* initiative being adopted across the four countries as originally intended which included: England's work on post registration career paths (Department of Health 2007b); Scotland's Advanced Nursing Practice framework (NHSScotland 2008); the work undertaken in Wales to develop clinical leaders (Welsh Assembly Government 2008b) or the operational framework on delegation decision making in place in Northern Ireland (Department of Health Social Services and Public Safety 2010).

Three recent reviews into failures in acute NHS hospitals in England, all published within six months of each other, cite the implications of inadequate nurse staffing and poor skill mix as factors which have contributed to poor quality of patient care (Francis 2013; Keogh 2013; National Advisory Group on the Safety of Patients in England 2013). The policy responses to these reports will likely result in a renewed focus on nurse staffing and consequently raise the profile of nursing workforce policy and planning. The drive to improve quality of care through better nurse staffing levels will however be in the context of continued pressures to contain costs and will result in tensions between workforce planning that is truly integrated with service and financial planning or a model which, as reported in this thesis, was driven principally by finances. This tension may however create the 'perfect storm' to drive inter-professional workforce planning and transformation through the delivery of different models of care with new workforce solutions across care settings and professional boundaries.

This thesis has provided new knowledge and insight into the impact of devolution on nursing workforce policy and planning in the UK. It has highlighted that although devolution has resulted in increased local flexibilities, this has not had a significant sustained impact on the overall profile or importance of nursing workforce planning. Devolution has created

increased opportunities for each of the four countries to 'try out' different approaches in relation to nursing workforce policy and planning, however the failure to learn lessons and adopt good practice has led to duplication of effort and an overall lack of progress.

A new approach is required to deliver real improvements in nursing workforce policy and planning that prevent a recurrence of 'boom and bust' cycles and the associated costs to the healthcare system, individual nurses and patients. In order to address these deficiencies there is the need first and foremost for nursing leaders both nationally and locally to have a clear responsibility for nursing workforce policy and planning decisions as these decisions are of critical importance to the future sustainability of the profession.

9.2 Recommendations

9.2.1 Overview of Recommendations

Based on the findings from this thesis, the researcher has identified four main recommendations for implementation, principally by the four country Chief Nursing Officers, Directors of Workforce and the Chief Executives of the government health departments.

In this section these recommendations are discussed and consideration is given to the potential barriers to their implementation along with suggested actions to enable their implementation.

The researcher intends to publish articles outlining the findings and recommendations from this thesis in nursing professional journals and health policy journals; with a view to disseminating the learning to a wider professional audience and stimulating further interest and debate in nursing workforce policy and planning.

9.2.2 Recommendation One

The research identified the need for clarification of the roles and responsibilities of the Chief Nursing Officers and their teams, specifically in relation to determining the nursing workforce implications of proposed health policies. This includes a clear requirement for increased professional accountability for the nursing workforce, particularly when new health policies are being developed. This involvement should ensure that the nursing profession has a greater influence in directing the future role development of the registered and non-registered nursing workforce, including articulating the impact of any particular health policy on the demand for Registered Nurses along with any requirements for additional training related to successful implementation of the new policy. This senior professional leadership during the development of health policies should also enable realistic timeframes to be set for the implementation of individual policies in line with the lead in times associated with commissioning or developing the required nursing workforce.

It is recommended that this professional nursing involvement should be at Chief Nursing Officer level or through a nominated deputy with specialist workforce expertise, working closely with relevant national organisations in the four UK countries, such as Health Education England; NHS Education for Scotland; Northern Ireland Practice and Education Council for Nursing or Workforce, Education and Development Services, Shared Services Partnership in Wales. This would be undertaken at a bilateral level within each of the four countries.

Several main barriers to the implementation of this recommendation can be identified, along with suggested strategies to overcome these. One of the main barriers is the lack of a senior nursing voice in the policy development process. However in the time since the interviews for the PhD research were carried out a new Chief Nursing Officer has been appointed in each of the four UK countries. These new appointments have created opportunities to

re-establish the professional nursing leadership role in relation to nursing workforce issues both within each country and across the UK.

A barrier to delivering improvements in nursing workforce planning is the low priority given to nursing workforce policy and planning, as identified in this research. Since the interviews were undertaken in 2008 several investigations into poor hospital care have been undertaken in England (including Francis 2013; Keogh 2013; National Advisory Group in the Safety of Patients in England 2013). The most prominent of these was the Public Inquiry into the failings in care at Mid Staffordshire NHS Foundation Trust led by Robert Francis QC, which was published in February 2013. These reviews highlighted the adverse impact of inadequate nurse staffing levels and low skill mix on the quality of patient care delivered. The findings from these reviews have served as an enabler highlighting the importance of nursing workforce policy and planning. This has resulted in an increased focus on 'safe' nurse staffing by Health Ministers in the four UK countries, leading to greater scrutiny of the methods used to set nurse staffing levels in the NHS. This renewed focus on nurse staffing has created an opportunity for the nursing profession to access and influence policy at the highest levels and also to contribute a greater leadership role in relation to nurse staffing and quality of care issues.

Investigations into failures in acute hospital care are also being undertaken in Scotland and Northern Ireland but the findings have yet to be reported. In the context of this increased interest in nurse staffing levels, there are currently workstreams underway in each of the four countries, under the leadership of the relevant Chief Nursing Officer, aimed at supporting NHS organisations to determine the numbers of nurses required to meet the care needs of their patients. Each of the four countries has however adopted a different approach to ensuring 'safe' nurse staffing levels.

Another barrier is that the increased pace and volume of policy development following devolution has made it more difficult for nurses to influence health policy. There has been an associated lack of co-ordination between different policy initiatives and some policies have resulted in unintended consequences for the nursing workforce, for example where changes in working practices for medical staff have impacted upon nursing roles or requirements for additional nursing staff. There is therefore a need for increased involvement of Chief Nursing Officers and their teams from the outset of new policy development to identify and address the potential implications of wider health policies on the nursing profession. This may also result in the identification of alternative workforce solutions, whereby nursing is not viewed as the default position in resolving deficits in other professions.

Chief Nursing Officers should influence Health Ministers and Chief Executives in the four country government health departments to ensure that there is a prerequisite for senior nursing representation in the development of all health policies. This influencing could be done directly by the Chief Nursing Officers in meetings with the Health Minister and Chief Executives by highlighting the challenges which have resulted from the absence of senior nursing leadership during policy development. There could also be indirect influencing through wider professional nursing networks including professional organisations and trade unions.

A further barrier identified in this thesis is the lack of capacity and capability within the nursing profession in relation to nursing workforce policy and planning. The reasons for this include a lack of focus on both nursing policy and nursing workforce issues within nurse education; limited opportunities for nurses to be exposed to, or contribute to the policy making process; the lack of senior nursing involvement in the development of workforce policy and the consequent low level of priority given to this work. Enablers to address this include commissioning structured education and training for nurses in relation to nursing workforce planning, development or utilisation and the creation of

senior nursing workforce roles both in NHS trusts and in government health departments. Similarly increased access to leadership programmes supporting nurses to be more politically astute will be beneficial in developing influencing skills to inform nursing policy development or encourage engagement with local politicians.

9.2.3 Recommendation Two

Another finding from this thesis was the increasing divergence between the four country Chief Nursing Officer roles following devolution. It is not clear if this role divergence was intentionally driven by the Chief Nursing Officers and Health Ministers or if it was principally associated with the increased policy divergence between countries. This divergence in the role of the Chief Nursing Officers and the increased focus on policy issues within individual countries has resulted in a weaker UK-wide nursing leadership voice which has been a barrier to the development of UK-wide nursing policy, UK-wide responses to professional nursing issues and the sharing good practice between countries. In addition to this the changing patterns of power and influence identified in this thesis included professional organisations and trade unions developing new ways of working, increasing their ability to influence politicians in the devolved administrations. This occurred in the absence of any other strong national nursing voice.

If this role divergence is supported by the Chief Nursing Officers and the Chief Executives of the government health departments in the four UK countries, then it is recommended that there should be increased transparency around this decision along with the opportunity for a UK-wide debate on the implications for the nursing profession. This debate has not yet taken place but it is recommended that this should be addressed as a matter of priority, particularly in view of the impending nursing shortage in the UK.

It is recommended that the debate is led by the four country Chief Nursing Officers with representation from the Nursing and Midwifery Council, professional organisations, trade unions and nurse leaders from across a range of settings including Directors of Nursing, Nurse Educators and Nurse Researchers. This debate should be progressed in a phased approach whereby following the initial debate within the profession there should be a wider debate with representatives from other healthcare professions, patient groups, patient safety bodies, healthcare regulators, health policy makers and policy think tanks for example the King's Fund or the Nuffield Trust.

This debate should seek to clarify the role of the Chief Nursing Officers both within individual countries and across the UK and consider the implications for the nursing workforce across all settings including the NHS, social care, independent and voluntary sectors. The nursing leadership voice in relation to non NHS sectors is currently absent from nursing policy development. This four country debate should enable consensus to be reached on nursing workforce policy and planning decisions including for example: approaches to preceptorship; post registration nursing career structures; the development and regulation of new nursing roles and agreement on the role, responsibilities and competencies of the non-registered workforce. These issues are of particular importance given that there is a single UK-wide nursing regulatory body for nursing and midwifery, the Nursing and Midwifery Council.

9.2.4 Recommendation Three

In addition to clarifying the roles of the four country Chief Nursing Officers as outlined under recommendation two, there is a need for better co-ordination of nursing workforce policy and planning across the four countries of the UK.

A barrier is that current approaches to nursing workforce policy and planning across the UK are fragmented and there are several reasons why this situation has arisen including:

- different political parties or coalitions in power in different countries of the UK
- different electoral cycles in different countries
- different nursing responses to health policies
- the larger size of England and the continued attempts of policy makers in England to dominate the other three UK countries.

It is recognised that several of these contributory factors will continue, however it is recommended that a UK-wide co-ordinating panel is established as an enabler to oversee nursing workforce policy and planning decisions. This would be a means of developing a more consistent approach to nursing workforce policy and planning issues across the UK.

This co-ordinating panel would work collaboratively to agree actions to ensure decisions taken in one country do not have a detrimental impact upon the nursing workforce supply in the other three countries, for example a change in terms and conditions for Registered Nurses. The success of such a co-ordinating panel would be dependent on an equal commitment from all four UK countries and the willingness to work in a truly collaborative basis to ensure that each country's views and ideas are represented and considered. One means of achieving this could be to have a strong independent panel chair. Membership should include professional nursing expertise from across employment settings both within the NHS and other sectors, workforce strategy and workforce planning expertise along with representation from other healthcare professions including medicine and allied health professions.

UK-wide initiatives could help to reduce potential shortages in nursing workforce supply through co-ordinated central work. Another objective of a successful UK-wide co-ordinating panel would be improvements in the adoption and spread of good practice in relation to nursing workforce planning.

9.2.5 Recommendation Four

The fourth recommendation is the need for improvements in the quality and consistency of published nursing workforce datasets in each of the four countries to support UK-wide nursing workforce modelling.

This thesis identified a number of deficiencies in relation to nursing workforce datasets within the four countries along with challenges comparing data between countries or amalgamating nursing workforce data on a UK-wide basis. The fragmentation of existing nursing workforce data is a barrier to obtaining accurate UK data on the number nurses entering NHS employment upon registration; the duration of that employment; the career paths of Registered Nurses; the movement of Registered Nurses across the UK; the number of Registered Nurses who leave the NHS to work in other healthcare sectors; the number of Registered Nurses who leave the NHS to work overseas and the number of Registered Nurses whose registration has lapsed and who could potentially be encouraged to return to nursing practice. This lack of robust information means that it is very difficult to assess the return on investment in nurse training for the NHS. Additionally there is a lack of nursing workforce data in all four UK countries relating to the nursing workforce employed in primary care, social care, independent sector, voluntary sector or in Higher Education.

An enabler would be a move towards increased standardisation of nursing workforce data, which could be promoted through the UK-wide workforce planners' networks but owing to the informal nature of this network it is unlikely to be delivered through this forum. Whilst the ideal solution would be to have an agreed UK-wide dataset for recording standardised nursing workforce data, this is unlikely as each country has its own established system for recording nursing workforce data which they would be reluctant to change. There could however be greater standardisation of data collection definitions including for example:

- pre-registration attrition datasets
- first destination employment upon registration
- categorisation of the non-registered nursing workforce
- categorisation of the registered nursing workforce
- recording of vacancy levels (short and long term)
- recording employment outwith the NHS.

The lack of strong leadership in relation to nursing workforce planning from both National Directors of Workforce and Chief Nursing Officers in the government health departments, as identified in this research, has been a barrier which has allowed individual organisations to take independent decisions to stop the publication of key nursing workforce datasets creating significant gaps in nursing workforce intelligence. One example is the Nursing and Midwifery Council published annual reports based on the UK registrant database for nursing and midwifery, however this practice ceased in 2008 and this data is not reported through any other source. The Nursing and Midwifery Council datasets provided useful trend information in a number of categories including the number of new registrants in each field of nursing in each of the four countries; the number of new registrants from outwith the UK and proxy data for the numbers of Registered Nurses in the UK exploring opportunities to work overseas. The Nursing and Midwifery Council data was one of the five datasets used in the workforce analysis section of this thesis. Another example is the NHS Information Centre in England has not published information on nurse vacancy levels since 2010. These decisions have been taken within organisations without recognition of the wider implications for planning the future nursing workforce.

Future proposals for improved UK-wide nursing datasets could be developed from within a UK-wide co-ordinating panel as outlined in recommendation three. Through this leadership network action could also be taken to influence the provision of key datasets such as those previously published by the Nursing and Midwifery Council.

9.2.6 Areas for Further Research

In addition to these recommendations this thesis has highlighted significant gaps in the available research evidence related to nursing workforce policy and planning in the UK. Suggested areas for investigation include the need for research specifically on:

- the implications of different approaches to determining nurse staffing levels in the four UK countries
- the cross border flows of nurses across the four UK countries
- the impact of apparent variations in nurse staffing numbers and skill mix in the four UK countries on the quality of patient care
- policy tensions between devolved issues and those not devolved, particularly professional regulation
- the different models of Chief Nursing Officer roles in the four UK countries

Undertaking a follow up study to this thesis with a similar cohort of interviewees would enable new insight to be gained into the further changes that have arisen since the original interviews were conducted in 2008, particularly as devolution has now been in place for 15 years. It would also be informative to obtain insight from Directors of Nursing and front-line nurses in each of the four countries in relation to nursing workforce policy and planning, particularly given the current increased policy attention and interest in nurse staffing levels.

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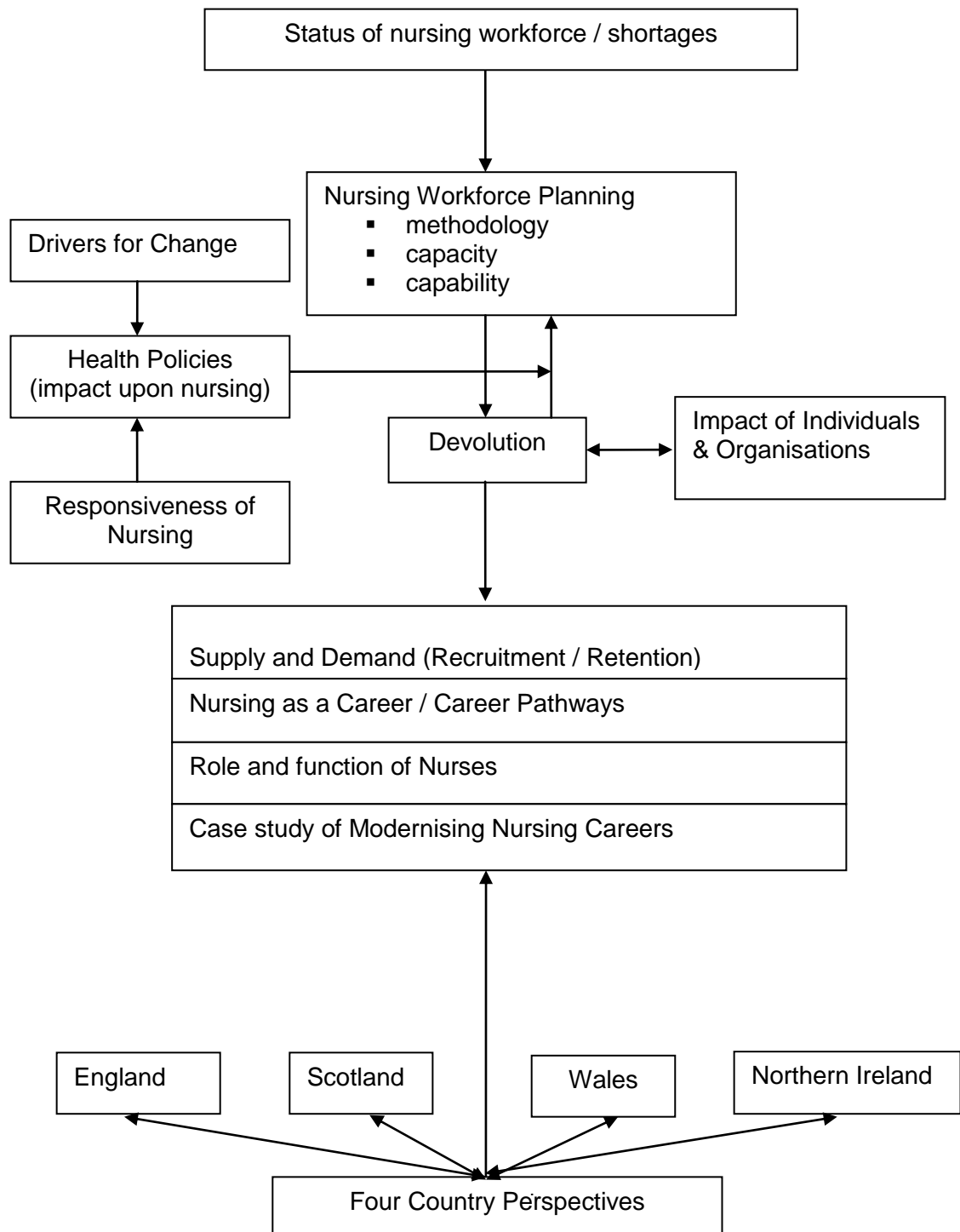
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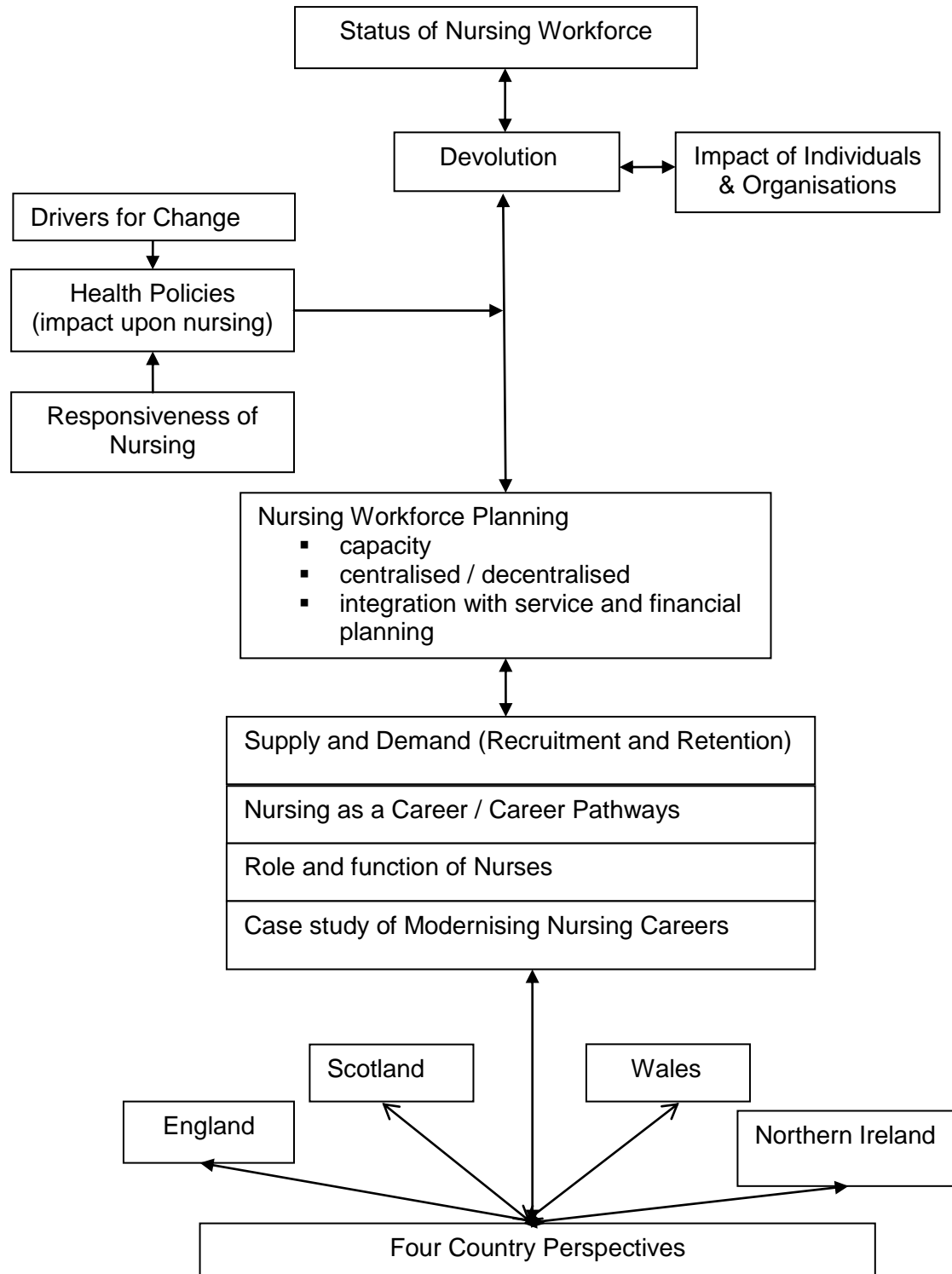
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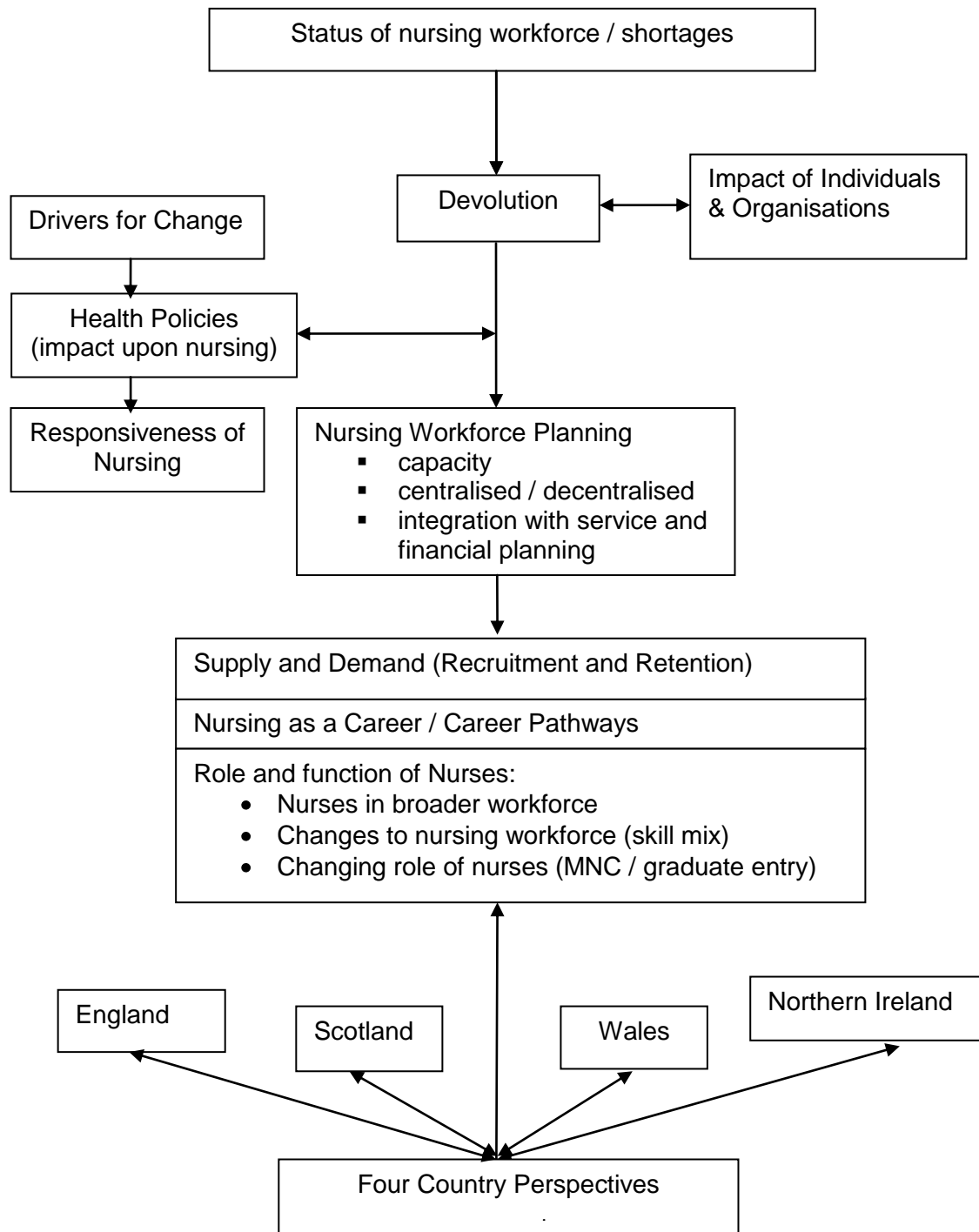
Adapted from Miles & Huberman (1994)

Appendix II

Conceptual Framework Version Two



Adapted from Miles & Huberman 1994



Adapted from Miles & Huberman (1994)

Appendix IV England – Policy / Event Log

Policy / Key Event (England)	Date
<i>The National Health Service: A Service with Ambitions</i> (Department of Health).	1996
<i>The New NHS Modern-Dependable</i> (Department of Health).	1997
<i>A First Class Service: Quality in the New NHS</i> (Department of Health).	1998
<i>Working Together. Securing a quality workforce for the NHS</i> (Department of Health).	1998
<i>Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Health Care</i> (Department of Health).	1999
<i>House of Commons Health Committee. Future NHS Staffing Requirements. Volume I and II</i> (House of Commons Health Committee).	1999
<i>Future Staffing Requirements. The Government's Response to the Health Committee Report on Future Staffing Requirements</i> (Secretary of State).	1999
<i>First Assessment. A Review of District Nursing Services in England and Wales</i> (Audit Commission).	1999
<i>Saving Lives: Our Healthier Nation</i> (Department of Health).	1999
<i>Continuing Professional Development: Quality in the New NHS</i> (Department of Health).	1999
<i>A Health Service of all the Talents: Developing the NHS Workforce</i> (Department of Health).	2000
<i>The NHS Plan. A Plan for Investment, a Plan for Reform.</i> (Department of Health).	2000
<i>Improving Working Lives Standard</i> (Department of Health).	2000
Introduction of Nurse Consultant Role in England.	2000
<i>The NHS Plan – an Action Guide for Nurses, Midwives and Health Visitors</i> (Department of Health).	2001
<i>Primary Care, General Practice and the NHS Plan: Information for GPs, Nurses, other Health Professionals and Staff Working in Primary Care in England</i> (Department of Health).	2001
<i>Brief Encounters: Getting the Best from Temporary Nursing Staff</i> (Audit Commission).	2001
<i>Educating and Training the Future Health Professional Workforce for England</i> (National Audit Office).	2001
<i>Shifting the Balance of Power within the NHS. Securing Delivery</i> (Department of Health).	2001
<i>Working Together, Learning Together: a Framework for Lifelong Learning for the NHS</i> (Department of Health).	2001
28 Workforce Development Confederations established.	2001

Policy / Key Event (England)	Date
NHS Modernisation Agency established.	2001
National Practitioner Programme launched.	2001
National Workforce Development Board established.	2001
<i>Liberating the Talents: Helping Primary Care Trusts and Nurses Deliver the NHS Plan</i> (Department of Health).	2002
<i>Shifting the Balance of Power: the Next Steps</i> (Department of Health).	2002
<i>Delivering the NHS Plan Next steps on Investment Next Steps on Reform</i> (Department of Health).	2002
<i>HR in the NHS Plan. More Staff Working Differently</i> (Department of Health).	2002
<i>Developing Key Roles for Nurses and Midwives – a Guide for Managers</i> (Department of Health).	2002
<i>Modern Matrons in the NHS: a Progress Report</i> (Department of Health).	2002
28 Strategic Health Authorities created.	2002
Skills for Health established.	2002
<i>Delivering the HR in the NHS Plan 2003</i> (Department of Health).	
<i>Freedom to Practice: Dispelling the Myths</i> (Department of Health and Royal College of Nursing).	2003
<i>Modern Matrons – Improving the Patient Experience</i> (Department of Health).	2003
<i>The Chief Nursing Officer's Review of the Nursing Midwifery and Health Visiting Contribution to Vulnerable Children and Young People</i> (Department of Health).	2004
<i>Delivering the NHS Improvement Plan: the Workforce Contribution</i> (Department of Health).	2004
<i>Delivering the HR in the NHS Plan 2004</i> (Department of Health).	2004
<i>Post Registration Development – A Framework for Planning, Commissioning and Delivering Learning Beyond Registration for Nurses and Midwives</i> (Department of Health).	2004
<i>The NHS Improvement Plan. Putting People at the Heart of Public Services</i> (Department of Health).	2004
<i>Code of Practice for the International Recruitment of Healthcare Professionals</i> (Department of Health).	2004
Appointment of new Chief Nursing Officer – Christine Beasley.	2004
NHS Professionals established as a Special Health Authority.	2004
Foundation Trusts introduced.	2004
Workforce Development Confederations merged with Strategic Health Authorities.	2004
NHS Employers established.	2004
<i>Creating a Patient-led NHS, Delivering the NHS Improvement Plan</i> (Department of Health).	2005

Policy / Key Event (England)	Date
<i>'Now I Feel Tall'. What a Patient-led NHS Feels Like</i> (Department of Health).	2005
<i>A National Framework to Support Local Workforce Strategy Development. A Guide for HR Directors in the NHS and Social Care</i> (Department of Health).	2005
NHS Institute for Innovation and Improvement replaces Modernisation Agency.	2005
Rationalisation of Strategic Health Authorities from 28 to 10.	2006
<i>Our Health, Our Care, Our Say: a New Direction for Community Services</i> (Department of Health).	2006
<i>From Values to Action: The Chief Nursing Officer's Review of Mental Health Nursing</i> (Department of Health).	2006
<i>Maximising Employment Opportunities in a Changing NHS</i> (NHS Employers).	2006
<i>HR High Impact Changes. An Evidence Based Resource</i> (Department of Health, NHS Partners and Manchester University).	2006
<i>The Regulation of Non-Medical Healthcare Professions</i> (Department of Health).	2006
Reconfiguration of Strategic Health Authorities reduced from 28 to 10.	2006
Primary Care Trusts reduced from 303 to 152.	2006
House of Commons Health Committee. <i>Workforce Planning: Fourth report of session 2006-07</i> , volume I and II (House of Commons Health Committee).	2007
<i>The Government Response to the Health Select Committee Report on Workforce Planning</i> (Secretary of State for Health).	2007
House of Commons Public Accounts Committee. <i>Improving the Use of Temporary Staff in the NHS Acute and Foundation Trusts</i> . Twenty-ninth report of session 2006-07 (House of Commons Public Accounts Committee).	2007
<i>Towards a Framework for Post Registration Nursing Careers. Consultation Document</i> (Department of Health).	2007
<i>Facing the Future: A Review of the Role of Health Visitors</i> (Chair Rosalynde Lowe, Queens Nursing Institute).	2007
<i>The Government Response to: Facing the Future: A Review of the Role of Health Visitors</i> (Department of Health).	2007
<i>Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century</i> (Department of Health).	2007
<i>Our NHS Our Future. NHS Next Stage Review Interim Report</i> (Department of Health).	2007
<i>Our NHS Our Future: NHS Next Stage Review Leading Local Change</i> (Department of Health).	2008
<i>High Quality Care for All NHS Next Stage Review</i> (Department of Health).	2008

Policy / Key Event (England)	Date
<i>A High Quality Workforce: NHS Next Stage Review</i> (Department of Health).	2008
<i>Visions for Better Healthcare</i> (Strategic Health Authorities).	2008
<i>Grow our Own Professionals for the New NHS Widening Participation in Learning Strategy Unit, Briefing Note</i> (Department of Health).	2008
Announcement that nursing will be all graduate entry from 2013 (Department of Health).	2009
<i>Transforming Community Services: Enabling New Patterns of Provision.</i> (Department of Health).	2009
<i>Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals.</i> (Department of Health).	2010
<i>Front Line Care. Report by the Prime Minister's Commission on the Future of Nursing and Midwifery in England</i> (Prime Minister's Commission on the Future of Nursing and Midwifery in England).	2010
Centre for Workforce Intelligence established.	2010
<i>Advanced Level Nursing: A Position Statement</i> (Department of Health).	2010

Appendix V Wales – Policy / Event Log

Policy / Key Event (Wales)	Date
<i>Better Health, Better Wales</i> (Welsh Office).	1998
<i>NHS Wales: Putting Patients First</i> (Secretary of State for Wales).	1998
The Government of Wales Act 1998	1998
<i>Releasing the Potential. A Strategic Framework for Nursing, Midwifery and Health Visiting in Wales into the 21st Century</i> (National Assembly for Wales).	1999
<i>First Assessment. A Review of District Nursing Services in England and Wales</i> (Audit Commission).	1999
National Assembly for Wales takes on full powers	1999
Appointment of new Chief Nursing Officer – Rosemary Kennedy.	1999
Policy introduced for Graduate Entry to Pre-Registration Nursing.	1999
<i>Access and Excellence</i> (National Assembly for Wales).	2000
<i>A Healthier Future for Wales</i> (National Assembly for Wales)	2000
<i>A Human Resources Strategy for NHS Wales. Delivering for Patients</i> (National Assembly for Wales).	2000
<i>Releasing the Potential. A Strategic Framework for Nursing, Midwifery and Health Visiting in Wales into the 21st Century. Briefing Paper 1 Creating the Potential - A Plan for Education</i> (National Assembly for Wales).	2000
<i>Promoting Health and Well Being: Implementing the National Health Promotion Strategy</i> (National Assembly for Wales).	2001
<i>Realising the Potential Briefing Paper 2: Aspiration, Action, Achievement – A Framework for Realising the Potential of Mental Health Nursing in Wales</i> (National Assembly for Wales).	2001
<i>Educating and Training the Future Health Professional Workforce in Wales</i> (National Audit Office Wales).	2001
<i>Improving Health in Wales – Structural Changes in the NHS in Wales</i> (National Assembly for Wales).	2001
<i>Improving Health in Wales: A Plan for the NHS and its Partners</i> (National Assembly for Wales).	2001
<i>Improving Health in Wales: The Future of Primary Care</i> (National Assembly for Wales).	2001
<i>Informing Healthcare</i> (National Assembly for Wales).	2002
<i>Realising the Potential Briefing Paper 3: Inclusion, Partnership and Innovation – A framework for Realising the Potential of Learning Disability Nursing in Wales</i> (National Assembly for Wales).	2002
<i>Realising the Potential Briefing Paper 5: Principles to Practice: A Framework for Realising the Potential of Child and Adolescent Mental Health Nursing in Wales</i> (National	2002

Policy / Key Event (Wales)	Date
Assembly for Wales).	
<i>The Review of Health and Social Care in Wales: The Report of the Project Team Advised by Derek Wanless</i> (Welsh Assembly Government).	2003
<i>Wales: a Better Country. The Strategic Agenda of the Welsh Assembly Government</i> (Welsh Assembly Government).	2003
Creation of 22 Local Health Boards coterminous with Local Authority Boundaries.	2003
Health (Wales) Act 2003.	2003
<i>Realising the Potential Briefing Paper 6: Achieving the Potential through Research and Development: A Framework for Realising the Potential through Research and Development in Wales</i> (National Assembly for Wales).	2004
<i>Realising the Potential Briefing Paper 7: Nurturing the Future: A Framework for Realising the Potential of Children's Nurses in Wales</i> (National Assembly for Wales).	2004
<i>Transforming Health and Social Care in Wales. Aligning the Levers of Change</i> (Audit Commission in Wales).	2004
<i>Making the Connections, Delivering Better Services for Wales</i> (Welsh Assembly Government).	2004
Launch of National Leadership and Innovation Agency for Healthcare (NLIAH).	2005
<i>Report of the Chief Nursing Officer for Wales</i> (Welsh Assembly Government).	2005
<i>Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century, a 10 year Strategy</i> (Welsh Assembly Government).	2005
<i>Making the Connections: Connecting the Workforce: The Workforce Challenge for Health</i> (Welsh Assembly Government).	2005
<i>Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century</i> (Welsh Assembly Government).	2005
<i>Healthcare Standards for Wales. Making the Connections Designed for Life</i> (Welsh Assembly Government).	2005
<i>The Revised Adult Mental Health National Service Framework and Action Plan for Wales</i> (Welsh Assembly Government).	2005
<i>Designed to Work: A Workforce Strategy to Deliver Designed for Life</i> (Welsh Assembly Government).	2006
<i>Making the Connections – Delivering Beyond Boundaries</i> (Welsh Assembly Government).	2006
Workforce Development Function established in National Leadership and Innovation Agency for Healthcare.	2006
The Government of Wales Act 2006	2006
<i>Designed to Improve Health and the Management of Chronic</i>	2007

Policy / Key Event (Wales)	Date
<i>Conditions in Wales</i> (Welsh Assembly Government).	
All Wales Temporary Agency Nurse Staffing Contract introduced.	2007
One Wales Coalition Agreement.	2007
Independent review of the implementation and outcomes of Agenda for Change.	2007
<i>Standards and Guidance for Role Redesign in the NHS in Wales</i> (National Leadership and Innovation Agency for Healthcare).	2008
<i>Free to Lead, Free to Care. Empowering Ward Sisters / Charge Nurses</i> (Welsh Assembly Government).	2008
<i>Nurture Ability and Develop Future Nurse Leaders. Modernising Nursing Careers Project Report:</i> (Welsh Assembly Government).	2008
<i>NHS Wales. A Strategy for a Flexible and Sustainable Workforce</i> (National Leadership and Innovation Agency for Healthcare).	2008
<i>Designed to Realise our Potential: A 'Beliefs and Actions' Statement for Nurses, Midwives and Specialist Community Public Health Nurses in Wales for 2008 and Beyond</i> (Welsh Assembly Government).	2008
<i>Inquiry into Workforce Planning in the Health Service and in Social Care</i> (National Assembly for Wales).	2008
<i>Post Registration Career Framework for Nurses in Wales</i> (Welsh Assembly Government).	2009
<i>A Framework for a School Nursing Service for Wales</i> (Welsh Assembly Government).	2009
<i>A Community Nursing Strategy for Wales. Consultation Document</i> (Welsh Assembly Government).	2009
Reorganisation of NHS Wales into Seven Health Boards and Three Trusts.	2009
<i>Delivering a Five Year Service, Workforce and Strategic Framework for NHS Wales</i> (Welsh Assembly Government).	2010
<i>Framework for Advanced Nursing, Midwifery and Allied Health Professional Practice in Wales</i> (National Leadership and Innovation Agency for Healthcare).	2010
<i>Setting the Direction. Primary and Community Services Strategic Delivery Programme</i> (Welsh Assembly Government).	2010
<i>Code of Conduct for Healthcare Support Workers in Wales</i> (Welsh Assembly Government).	2010

Appendix VI Northern Ireland – Policy / Event Log

Policy / Key Event (Northern Ireland)	Date
<i>Health and Wellbeing: into the Next Millennium. Regional Strategy for Health and Social Wellbeing 1997-2002</i> (Department of Health and Social Services Health).	1997
<i>Well into 2000, A Positive Agenda for Health and Wellbeing</i> (Department of Health and Social Services).	1997
<i>Fit for the Future: A Consultation Document on the Government's Proposals for the Future of the Health and Personal Social Services in Northern Ireland</i> (Department of Health and Social Services).	1998
<i>Putting it Right: the Case for Change in Northern Ireland's Health Service</i> (Department of Health and Social Services).	1998
<i>Valuing Diversity – a Way Forward. A Strategy for Nursing, Midwifery and Health Visiting</i> (Department of Health and Social Services).	1998
Northern Ireland Act	1998
<i>Fit for the Future: A New Approach. The Government's Proposals for the Future of Health and Personal Social Services in Northern Ireland</i> (Department of Health and Social Services).	1999
The Departments (NI) Order.	1999
Devolution introduced.	1999
<i>Building the Way Forward in Primary Care</i> (Department of Health, Social Services and Public Safety).	2000
<i>A Nursing Vision of Public Health. All Ireland Statement on Public Health and Nursing</i> (Department of Health, Social Services and Public Safety and Department of Health and Children).	2001
<i>Report of the Acute Hospitals Review Group / Hayes Report</i> (Department of Health, Social Services and Public Safety).	2001
<i>Programme for Government: Making a Difference 2002-2005</i> (Office of the First Minister and Deputy First Minister).	2001
<i>Review of Nursing, Midwifery and Health Visiting Workforce</i> (KPMG Consulting and Department of Health, Social Services and Public Safety).	2002
<i>Developing Better Services: Modernising Hospitals and Reforming Structures</i> (Department of Health, Social Services and Public Safety).	2002
<i>Investing for Health</i> (Department of Health, Social Services and Public Safety).	2002
<i>The Employer of Choice. A Strategy for Managing and Developing People in the Health and Personal Social Services</i> (Department of Health, Social Services and Public Safety).	2002

Policy / Key Event (Northern Ireland)	Date
Northern Ireland Assembly suspended	2002 October
<i>Nursing and Midwifery Workforce Planning Review</i> (Department of Health, Social Services and Public Safety).	2003
<i>The Future of Health and Social Services in Northern Ireland: Key Trends in Population, Service Delivery and Workforce</i> (Department of Health, Social Services and Public Safety).	2003
<i>From Vision to Action. Strengthening the Nursing Contribution to Public Health</i> (Department of Health, Social Services and Public Safety).	2003
<i>Community Health Nursing. Current Practice and Possible Futures</i> (Department of Health, Social Services and Public Safety).	2003
<i>Strategic Direction in Community Nursing in Northern Ireland</i> (Department of Health, Social Services and Public Safety).	2003
<i>A Healthier Future, A Twenty Year Vision for Health and Wellbeing in Northern Ireland</i> (Department of Health, Social Services and Public Safety).	2004
<i>Independent Review of Health and Social Care Services in Northern Ireland / Appleby Review</i> (Department of Health, Social Services and Public Safety).	2005
<i>Realising the Vision. Nursing for Public Health</i> (Department of Health, Social Services and Public Safety).	2005
<i>An Exploration of Nursing and Midwifery Roles in Northern Ireland's Health and Personal Social Services</i> (Northern Ireland Practice and Education Council).	2005
<i>Review of the Nursing, Midwifery and Health Visiting Workforce, Final Report</i> (Department of Health, Social Services and Public Safety).	2005
<i>Guidance on International Nursing Recruitment</i> (Department of Health, Social Services and Public Safety).	2005
<i>Caring for People Beyond Tomorrow</i> (Department of Health, Social Services and Public Safety).	2005
<i>Regional Redesign of Community Nursing Project</i> (Department of Health, Social Services and Public Safety).	2006
<i>Development Framework Final Project Report</i> (Northern Ireland Practice and Education Council).	2006
<i>Careers Foundation Paper</i> (Northern Ireland Practice and Education Council).	2006
<i>The Review of Public Administration. Discussion Paper on the Role of the Nursing and Midwifery Function within the New Structures</i> (Department of Health, Social Services and Public Safety).	2006
<i>The Health of the Public in Northern Ireland. Chief Medical Officer Report</i> (Department of Health, Social Services and	2006

Policy / Key Event (Northern Ireland)	Date
Public Safety).	
<i>Review of Public Administration: Consultation on Draft Legislation to Establish Five New Integrated Health and Social Services Trusts</i> (Department of Health, Social Services and Public Safety).	2006
Appointment of new Chief Nursing Officer – Martin Bradley.	2006
18 Health and Social Services Trust merged into 5 Health and Social Care Trusts.	2007
Northern Ireland Assembly reinstated.	2007 May
<i>Proposals for Health and Social Care Reform</i> (Department of Health, Social Services and Public Safety).	2008
<i>Delivering the Bamford Vision: The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability</i> (Department for Health, Social Services and Public Safety).	2008
<i>Nursing and Midwifery Review Summary 2009</i> (Department of Health, Social Services and Public Safety).	2009
<i>Partnership for Care. Northern Ireland Strategy for Nursing and Midwifery 2010-2015</i> (Department of Health, Social Services and Public Safety).	2010

Appendix VII UK – Policy / Event Log

Policy / Key Event (UK)	Date
Health Act	1999
<i>Agenda for Change</i> (Department on Health).	1999
<i>Agenda for Change. Final Agreement</i> (Department of Health).	2004
Implementation of Agenda for Change commenced	2004 – 2006
<i>Modernising Medical Careers</i> (Department of Health).	2004
Preceptorship Guidelines (Nursing and Midwifery Council)	2006
<i>Modernising Nursing Careers</i> (Department of Health, Scottish Executive, Welsh Assembly Government and the Department of Health, Social Services and Public Safety).	2006
<i>The Regulation of Non-Medical Healthcare Professions</i> (Department of Health).	2006
<i>Trust Awareness and Safety: Regulation of Health Professionals in the 21st Century</i> (Secretary of State for Health).	2007
Aspiring to Excellence: Final Report of the Independent Inquiry into Modernising Medical Careers. (<i>Tooke</i>)	2008
<i>Developing New Standards for Nursing Education in the UK</i> (Nursing and Midwifery Council).	2008
New Standards for Pre-Registration Nurse Education (Nursing and Midwifery Council).	2010

Appendix VIII - Scanned Copy of Letter from Committee (A) Multi-Centre Research Ethics Committee (MREC) for Scotland

Multi-Centre Research Ethics Committee for
Scotland

Secretariat
Deaconess House
148 Pleasance
Edinburgh
EH8 9RS
Telephone 0131 536 9026
Fax 0131 536 9346
www.corec.org.uk



Ms Pauline Milne
Programme Manager Workforce Planning and
Workload
Directorate of Nursing, Midwifery and Allied
Health Professions
Scottish Executive Health Department
Room GE.06
St. Andrew's House
Regent Road
Edinburgh
EH1 3DG

Date: 7 March 2006
Your Ref.:
Our Ref.:

Enquiries to: Walter Hunter
Extension: 89026
Direct Line: 0131 536 9026
Email: walter.hunter@lhb.scot.nhs.uk

Dear Ms Milne

Devolution and Nursing Workforce Policy and Planning in the 4 countries of the United Kingdom 1997-2007

I refer to the exchange of e-mail messages in which you sought clarification on whether the above PhD project required ethical review and approval.

The Chairman of the Multi-Centre Research Ethics Committee for Scotland, Committee A was consulted about your project. Professor Lees has advised that the project is not one that is required to be ethically reviewed under the terms of the Governance Arrangements for Research Ethics Committees in the UK. There is therefore no requirement for you to submit an application for ethical review.

I hope this clarifies the position but if you require further information please don't hesitate to contact me again.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Walter Hunter'.

WALTER HUNTER
Committee Co-ordinator

Chairman Professor Kennedy Lees
Vice-Chairman Dr George Masterton

Appendix IX Flyer Providing Overview of Research Study

Devolution and Nursing Workforce Policy and Planning in the four countries of the United Kingdom over the period 1997-2008 PhD Study

This communication is to inform you of a PhD research study that I am currently undertaking on nursing workforce policy and planning, examining the differing approaches in the four countries of the UK. Further correspondence will be sent to you directly, before the end of September 2007, asking you if you will be willing to be interviewed, in confidence, as part of the study. In the meantime if you are interested in finding out more about this research please do not hesitate to contact me:

Pauline Milne on mobile xxxxx or email xxxxxxx

The research study being undertaken has the following aims:

- to investigate the influence of healthcare policies and other factors on nursing workforce planning in devolved administrations of the UK
- to examine the relationship between key healthcare policies, nursing workforce policies and nursing recruitment and retention, comparing the 4 countries of the UK
- to identify if the key policies resulted in the planned changes to the nursing workforce, necessary for implementation of these policies.

I am working on the PhD on a part-time basis through Queen Margaret University, Edinburgh. I am currently a Deputy Director of Nursing, Mid Essex Hospitals NHS Trust and was previously Programme Manager, Workforce Planning and Workload within the Scottish Executive Health Department.

The Director of my PhD studies is Professor James Buchan and he can be contacted at: Faculty of Health and Social Sciences, Queen Margaret University, Clerwood Terrace, Edinburgh, EH12 8TS xxxxxxx or telephone xxxxx

I hope to carry out key informant interviews with Chief Nursing Officers, Directors of Human Resources / Workforce within the Health Departments and other critical stakeholders in each of the 4 countries. I will therefore be contacting many of you in the near future to seek your agreement to participate in this study. Participation in the study will involve an interview with the researcher over the period January-April 2008. There may also be a follow up interview, most likely by telephone, at a later date.

Following completion of this work it is intended that findings will be published outlining what have been the key policy drivers and most successful approaches in relation to nursing workforce planning across the United Kingdom over the past decade.

Thank you for supporting this work.

Appendix X Copy of Letter Sent to Potential Participants



Queen Margaret University
EDINBURGH

19th September 2007

Name
Job Title
Address

Dear Name

PhD study – Devolution and Nursing Workforce Planning

I am a post graduate research student from the School of Health Sciences at Queen Margaret University, Edinburgh. I am undertaking part-time PhD studies and the title of my project is "Devolution and Nursing Workforce Policy and Planning in the 4 countries of the United Kingdom (1997-2008). The aims of the study are to:

- investigate the influence of healthcare policies on nursing workforce planning in the devolved administrations
- examine the relationship between key healthcare policies, nursing workforce policies and nursing recruitment and retention, comparing the four UK countries
- identify if the key policies resulted in desired changes to the nursing workforce necessary for implementation of these policies

The findings of the project will be of value to you as, to date, limited research has been carried out in this area. I am seeking to undertake key informant interviews with senior personnel from health departments, professional organisations, trade unions, academic institutes and other essential bodies.

I am contacting you to seek your agreement to participate in this study. I have enclosed an information sheet for potential participants and a consent form. If you are willing to be involved in this study I would be grateful if you could complete the enclosed consent form and return this to me in the stamped addressed envelope supplied. I will then contact you to arrange an interview which will be held during the period January – April 2008. If you require any further information or clarification in relation to this work, please do not hesitate to contact me on telephone number xxxxxx or email xxxxxx

I would like to take this opportunity to thank you for your support with this research project.

Yours sincerely

Pauline Milne

Pauline Milne
cc Professor James Buchan, Director of Studies

Appendix XI Copy of Information Sheet for Potential Participants



Queen Margaret University
EDINBURGH

Information Sheet for Potential Participants

My name is Pauline Milne and I am a post graduate research student at Queen Margaret University, Edinburgh. I am undertaking part-time PhD studies and the title of my project is: "Devolution and Nursing Workforce Policy and Planning in the 4 countries of the United Kingdom (1997-2008)".

The aims of the study are to:

- investigate the influence of healthcare policies on nursing workforce planning in the devolved administrations
- examine the relationship between key healthcare policies, nursing workforce policies and nursing recruitment and retention, comparing the four UK countries
- identify if the key policies resulted in desired changes to the nursing workforce necessary for implementation of these policies

I hope that the findings of the project will be value to you as, to date, limited research has been undertaken in this area.

The study has been granted ethics approval.

As part of my study I am seeking to undertake key informant interviews with senior personnel from health departments, professional organisations, trade unions, academic institutes and other essential bodies. I am seeking your participation in this study owing to your expertise and experience in the field of healthcare policy or nursing workforce planning.

If you agree to participate in the study, you will be asked to take part primarily in one focused interview which will be held in a convenient location in your local area. It is planned that the interview will be conducted during the period January – April 2008 and should last no longer than 2 hours. Following the interview a written record will be prepared and sent to you for your approval. There may be a requirement to contact you again following the interview to seek clarification on a matter which has arisen or to seek additional information in relation to a point raised in another interview. The researcher is not aware of any risks associated with

undertaking this work. You will be free to withdraw from the study at any stage and you would not have to give a reason.

All data will be anonymised as much as possible, but you may be identifiable from tape recordings of your voice. Your name will be replaced with a participant number, and it will not be possible for you to be identified in any reporting of the data and information gathered.

The results of the PhD may be published in journals or presented at conferences in the future.

My Director of Studies is Professor James Buchan and his contact details are provided below.

If you have read and understood this information sheet, have no outstanding questions and are willing to participate in this study please now complete the consent form and return in the stamped addressed envelope provided.

Thank you for your assistance with this research project.

Contact details for the researcher:

Name of researcher: Pauline Milne
Address: xxxxxxxxxxxxxx

Email: xxxxxxxxxxxxxxxx
Mobile: xxxxxxxxxxxxxxxx

Contact details for Director of Studies:

Name of adviser: Professor James Buchan

Address: Faculty of Health and Social Sciences
Queen Margaret University
Queen Margaret University Drive
Musselburgh
East Lothian
EH21 6UU

Email : xxxxxxxxxxxxxxxx

Telephone: xxxxxxxxxxxxxxxx

Appendix XII Copy of Consent Form for Participants



Queen Margaret University
EDINBURGH

Consent Form

Devolution and Nursing Workforce Policy and Planning in the 4 countries of the United Kingdom (1997-2008)

I have read and understood the information sheet and this consent form. I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in this study.

I understand that I have the right to withdraw from this study at any stage without giving any reason.

I agree to participate in this study.

Name of participant: _____

Signature of participant: _____

Signature of researcher: _____

Date: _____

Contact details of the researcher:

Name of researcher: Pauline Milne
Address: xxxxxxxxxxxx
Email: xxxxxxxxxxxx
Telephone: xxxxxxxxxxxx

Appendix XIII Interview Progress Record

Reference Date of Interview Length of Interview	Tape Review	Transcript Sent to Key Informant	Transcript Approved by Key Informant
SC01 24-01-08 1 hour 45 mins	Complete 17-05-08	21-10-08 Reminder 18-01-09 Final email sent	Returned 19-03-09 No changes
SC02 24-01-08 1 hour 19 mins	Complete 20-05-08	21-10-08 Reminder 18-01-09	Returned 21-01-09
SC03 25-01-08 1 hour 8 mins	Complete 25-05-08	21-10-08	Returned with sections highlighted which are confidential 29-10-08
SC04 25-01-08 43.5 mins	Complete 26-05-08	21-10-08 Reminder 18-01-09	Returned with minor amendments on 08-04-09
SC05 25-01-08 1 hour 10 mins	Complete 01-06-08	21-10-08 Reminder 18-01-09	Returned 07-02- 09 with minor amendments
SC06 28-01-08 1 hour 49 mins	Complete 08-06-08	21-10-08	Returned 12-11-08
SC07 28-01-08 1 hour 6 mins	Complete 21-06-08	21-10-08	Returned 22-10-08 minor amendments
ENG01 06-02-08 43 mins	Complete 29-06-08	21-10-08	Returned 29-10-08 No comments
ENG02 06-02-08 56 mins	Complete 12-07-08	21-10-08	Returned 27-10-08 minor amendments
ENG03 06-02-08 1hr 22mins	Complete 20-07-08	21-10-08 Reminder 18-01-09	Returned 22-01-09 Requested assurances re anonymity for all those referred to and this was confirmed
ENG04 18-02-08 1hr 20mins	Complete 26-10-08	06-11-08 Reminder 22-01-09	Returned 19-03-09 No changes
ENG05 19-02-08 1 hour	Complete 26-10-08	06-11-08 Reminder 18-01-09	No reply by 31-03-09 so as mentioned in

Reference Date of Interview Length of Interview	Tape Review	Transcript Sent to Key Informant	Transcript Approved by Key Informant
			email it is assumed that interviewee is in agreement
ENG06 19-02-08 1hr 48mins	Complete 10-08-08	06-11-08 Reminder 18-01-09	Returned 19-03-09 No changes
ENG07 19-02-08 51mins	Complete 17-08-08	06-11-08 Reminder 18-01-09 Reminder sent 29-03-09 and requested response by 17-04-09	Returned 1-04-09 with amendments
ENG08 03-03-08 52mins	Complete 21-08-08	06-11-08 Reminder 18-01-09	No reply by 31-03-09 so as mentioned in email it is assumed that interviewee is in agreement
ENG09 03-03-08 51mins	Complete 24-08-08	25-01-09	Minor amendments received in blue font 06-04-09
ENG10 12-03-08 1hr 18mins	Complete 07-09-08	25-01-09	Returned. In agreement with content however concerned re identifiable data from p 28 /29. This has been highlighted and will not be used in analysis
ENG11 01-04-08 1hr 23mins	Complete 27-09-08	25-01-09	Returned No changes
WAL01 13-03-08 1 hour 16 mins	Complete November 2008	15-03-09 Chaser sent 16-06-09	Replied 30-06-09 happy with content
WAL02 14-04-08 59.5mins	Complete 16-11-08	15-03-09	Returned 17-03-09 Minor tracked changes
WAL03 14-04-08 1hour 5mins	Complete 17-11-08	15-03-09 Chaser sent 16-06-09	Agreed content 30-06-09

Reference Date of Interview Length of Interview	Tape Review	Transcript Sent to Key Informant	Transcript Approved by Key Informant
WAL04 15-04-08 1 hour 3 mins	Complete 27-11-08	15-03-09	Returned no changes 23-03-09
WAL05 15-04-08 1 hour 30mins	Complete 1-12-08	15-03-09 Chaser sent 16-06-09	Returned no changes 22-07-09
WAL06 16-04-08 1 hour 23mins	Complete 30-01-09	15-03-09	Returned no changes 17-04-09
NI01 21-04-08 1 hour 1 mins	Complete 11-01-09	29-03-09 Chaser sent 16-06-09	Returned no changes 22-07-09
NI02 21-04-08 1 hour 34 mins	Complete 25-01-09	29-03-09	Returned 02-04-09 no changes
NI03 22-04-08 1 hour 7 mins	Complete 01-02-09	29-03-09 Out of office until end of April / May Emailed secretary Chaser sent 16-06-09	Returned with amendments 19- 06-09
NI04 22-04-08 1 hour 12 mins	Complete 02-02-09	29-03-09	Returned 08-04-09 No changes
NI05 22-04-08 1 hour 8 mins	Complete	29-03-09 Chaser sent 16-06-09 and 21-07-09	Returned 21-07- 09 satisfied with content
NI06 22-05-08 1 hour 32 mins	Complete	05-04-09	Returned 06-04-09 No changes

Appendix XIV Sample Mind Map (Devolution)



Appendix XV
Summary of Key Policies Over The Period 1997-2008 as Reported by Interviewees

	Reported Policies					
	1	2	3	4	5	6
SC01	Facing the Future					
SC02	Waiting times	Kerr report	Career framework			
SC03	Delivering for Health Agenda (Scottish Executive 2005)	Joint Futures and the preceding policy				
SC04	Devolution - confidence in the country to do what is right from a health policy perspective for the people of Scotland. The policy drive to address health inequalities	Shifting the Balance of Care	Single system and partnership working. Staff governance	Public involvement / engaging with communities		
SC05	perceptions of understaffing following the purchaser / provider split	GP contract / NHS 24 / development of new roles				
SC06	Facing the Future	Mental Health Care and Treatment Act	Delivering Care, Enabling Health Nursing Strategy (Scottish Government 2006)	Modernising Nursing Careers	Nursing Workload Measurement work	
SC07	Everything really as nursing is such a huge part of what happens within the health service					

	Reported Policies					
	1	2	3	4	5	6
ENG001	Short termism	New money in the system in 2000/01 leading to huge increases in the number of nurses in the system	Big numbers of internationally recruited nurses coming into certain parts of the labour market			
ENG002	Funding, increasing capacity and the expansion of the nursing workforce	Advanced and extended nursing roles. Nurse led services / prescribing	Ageing and demographics of population	Acute / community shift	Competitiveness due to commissioning / provider split - implications for clinicians	
ENG003	Health policy at the moment is not a whole systems approach for example Agenda for Change was positive for nursing profession however the affordability aspects resulted in nurses being made redundant					
ENG004	Health policies around primary care in particular	Structural change within the health service	Agenda for Change and the new job evaluation systems	Nurse prescribing	Expanding roles through challenging of barriers and boundaries	
ENG005	Different changes with devolution - in England "creeping privatisation" is an issue	Target driven service	Impact of WTD and EU Funding created opportunities for nurses to take on new roles	Blurring of boundaries between health and social care (in NI)		

	Reported Policies					
	1	2	3	4	5	6
ENG006	The very large increase in nursing numbers - very huge and significant	Nursing is crucial for delivery of all health policies - shift of care to community / Primary Care	Modernising Nursing Careers and the two current consultations Pre-registration nurse education (NMC) and post registration career pathways (DH)			
ENG007	NHS Plan (more staff, better paid and working differently). Increased workforce through 3 strand approach – Return to Practice, overseas recruitment and increasing numbers in training	Agenda for Change to address the large number of pay bands and inequalities as regards pay issues	The way the NHS has devolved responsibility for determining staffing requirements to frontline organisations (based on assessment of needs) Lack of effective workforce planning	Clinical Governance / Skills Escalator	Improving Working Lives	Standards for Better Health
ENG008	Agenda for Change	National Service Frameworks	New roles that have been created	Project 2000		
ENG009	NHS Plan / increased funding / more and different nurses / international recruitment	Improving Working Lives / National Childcare Strategy	Nursing Strategy	Upskilling nurses to move into specialist and consultant roles	Strap line - more staff working differently	

	Reported Policies					
	1	2	3	4	5	6
ENG010	A Health Service for all Talents - precursor to nursing expansion	Commissioning a Patient Led NHS	Our Health Our Care Our Say	Darzi work more recently. Every People Matters work linked to this	Health Select Committee Review	Modernising Nursing Careers - more philosophical than practical
ENG11	NHS Plan triggered the direction of travel. Recognition that there needed to be massive investment in education and training - massive expansion. Other strategies flow from NHS Plan	Becoming a service that is more patient focused	Promotes health and healthy living	Shift from acute to primary care	Team working, role development associated with care pathways. Challenging professional boundaries	Clear career pathways
WAL01	Strategy for Nursing. Releasing the Potential - first ever nursing strategy. Seven briefing papers followed from this including Creating the Potential which introduced all graduate entry	Other briefing papers were on MH, LD, Maternity, Children's Services and Research				
WAL02	NHS Plan - significant as it gave commitments to increased number of nurses	Designed for Life (10 year strategy) detailed how Wales would implement findings from Wanless Review. Signaled the move from secondary to primary care	Fulfilled Lives, Supportive Care (10 year social care strategy) sit well together as can't look at health in isolation from social care	One Wales publication by coalition Government		

	Reported Policies					
	1	2	3	4	5	6
WAL03	Designed for Life (10 year strategy). From here policies now are much crisper / harder	Chronic Conditions Framework	One Wales	Structural changes to the NHS in Wales	Impact of UK policy / legislation such as Mental Health Act, Mental Capacity Act	
WAL04	Move from acute to community settings. Skill mix in community teams. Development of community nursing workforce	Funding crisis				
WAL05	Designed for Life (10 year strategy). Strategic direction has shifted from secondary to primary care. As nursing is an element of the workforce it has a major / significant impact upon the direction and travel	Releasing the Potential - put a focus on the nursing contribution to healthcare				
WAL06	Structural reform and Trust mergers	Designed for Life (10 year strategy) in wake of the Wanless Review. Provides a blueprint for how Wales sees service delivery moving forward - whole system / integrated partnership approach				

	Reported Policies					
	1	2	3	4	5	6
NI 01	Extension of what nurses do has shifted quite a lot - taking on work previously done by junior doctors etc. Focus has moved away from caring side to the more technical side	Policy moving more towards community based nursing				
NI 02	Over past 10 years - devolution has come and gone and come back again	Prior to this devolved government - policy was basically watered down, drip fed version of what was being done in England - applied to a completely different culture and country. Abundance of reviews	Impact of structural re-organisations and reduction in the number of hospitals	Push for primary care led services. Community development work / LTCs	In all of these policies there is a push for nurses to take on additional tasks and new roles	
NI 03	Nearly all of health policy impacts on those at the frontline delivering it	Political changes – intermittent direct rule and devolution	Targets – waiting lists / beds	Nursing workforce deficits since Conservative Administration Mismatch between policies to improve quality of care but there was a deficit of trained staff to deliver this		

	Reported Policies					
	1	2	3	4	5	6
NI 04	Better Patient, Better Care - patient focused care	Human Organs Enquiry - nursing role in breaking bad news	NMC Mentorship policies	Policies around training nurses from HCSW base. Work based approach rather than just academic route	Increased focus on quality standards and infection control	
NI 05	Workforce planning or lack of policy in workforce planning	Huge shortages of nurses at beginning of decade - response to economic downturn	Agenda for Change - as a policy instrument it will configure the face of nursing for the next 5-10 years.	A range of other policies which are gradually changing the role of the nurse e.g. nurse prescribing		
NI 06	Focus on Public Health "Investing for Health" - targeting health and social inequalities. Held up in Europe as one of the most articulate public health policies around	From Investing for Health there is a 20 year strategy "A Healthier Future" - agreed by all parties	Developing Better Services - future plans for secondary care. Shift of activity from secondary to primary care / reduction in numbers of acute hospitals			